

Delivery Via Email: <a href="mailto:lburrell@thecommons-umrc.com">lburrell@thecommons-umrc.com</a>; <a href="mailto:MBrinker@thecommons-umrc.com">MBrinker@thecommons-umrc.com</a>;

July 21, 2021

CCN: 375488 Cycle Start Date: July 1, 2021 Survey Event ID: C7JI11

Ms. Ladeana Burrell, Administrator The Commons 301 South Oakwood Road Enid, OK 73706

Dear Ms. Burrell:

On **July 1, 2021,** agents from our office concluded a Covid-19 Focused survey in conjunction with a complaint investigation at The Commons to determine if your facility was in compliance with the Federal requirements for nursing home participation in the Medicare and/or Medicaid programs. This inspection found the most serious deficiency(ies) in your facility to be:

Deficiency level "K"; a pattern of deficiencies that constitutes immediate
jeopardy to resident health and safety, as evidenced by the CMS-2567,
whereby significant corrections are required.

Although the survey team has determined that your facility **removed the immediate jeopardy** to resident health and safety, your facility has **not yet achieved substantial compliance** with the federal participation requirements for nursing facilities in the Medicare and Medicaid programs.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

#### **Determination of Substandard Quality of Care**

The following deficiencies have been determined to constitute substandard quality of care.

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F0600 -- S/S: K -- 483.12(a)(1) -- Free from Abuse And Neglect;
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F0607 -- S/S: K -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies;

F0609 -- S/S: K -- 483.12(c)(1)(4) -- Reporting of Alleged Violations;

F0610 -- S/S: K -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation

In accordance with sections 1819(f) and/ or 1919(f) of the Social Security Act and regulations at 42 CFR Part 498, the Oklahoma State Department of Health is providing



notice as authorized by the Dallas Regional Office that the Centers for Medicare and Medicaid Services (CMS) has made a determination of Substandard Quality of Care which led to an extended or partial extended survey. This will result in the State withdrawing your Nurse Aide Training and Certification program (NATCEP) for two years.

Statutory provisions at 1819(g)(5)(c) and/or 1919(g)(5)(c) of the Social Security Act and the federal regulation at 42CFR488.325(h), require the Oklahoma State Department of Health to issue notice to the attending physician of each resident who was identified as having been subject to substandard quality of care.

You are required to provide the following information to the Oklahoma State Department of Health within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have been subject to substandard quality of care. A list of the affected residents is attached.

Pursuant to §488.325(g), your failure to provide to the Oklahoma State Department of Health within ten (10) working days the name and address of the attending physician for each of the listed residents will result in termination of participation or imposition of alternative remedies

In addition, 1819(g)(5)(c) and/or 1919(g)(5)(c) of the Social Security Act and the federal regulations at 42CFR488.325(h) require the Oklahoma State Department of Health to issue notice of the substandard quality of care to the Oklahoma State Board of Examiners of Long Term Care Administrators (OSBELTCA). The Oklahoma State Department of Health is issuing notice of the substandard quality of care to OSBELTCA and including a copy of this letter and the enclosed CMS 2567. If you need more information about OSBELTCA's handling of this notice, please contact OSBELTCA directly.

### Plan of Correction (PoC)

You must submit an acceptable plan of correction within ten calendar days of receipt of the complete CMS-2567. An acceptable PoC shows a provider's willingness and ability to achieve and maintain compliance and to provide residents the care and services they need. An acceptable PoC demonstrates correction has been, or will be achieved and makes the provider's allegation of compliance credible. An acceptable PoC is required before a revisit (to verify correction) will be made. To be considered acceptable, your PoC must contain the following:

 How corrective action will be accomplished for those residents found to have been affected by the deficient practice.



- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. This is part of your quality assurance plan. At the revisit, the quality assurance plan shall be reviewed to determine the earliest date of compliance. If there is no finding of continuing non-compliance, evidence of quality assurance being implemented will be required to establish a correction date earlier than the date of the revisit.
- An acceptable completion date for correction of each deficiency. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

In addition, the PoC must contain only a Plan of Correction OR evidence refuting each deficient practice in a deficiency citation. It must be specific and realistic, stating exactly how the deficiency will be or was corrected.

Please submit your plan of correction under the second column on the Form CMS-2567. Address each deficiency, and include the month, day, and year of the expected completion date in the third column. Sign, date, and indicate your title in the appropriate blocks on page 1 of the form. Return the CMS-2567 with the PoCs to:

#### LTCEnforcement@health.ok.gov

OR

Long Term Care Enforcement Division Protective Health Services Oklahoma State Department of Health 123 Robert S. Kerr Ave., Ste. 1702 Oklahoma City, OK 73102-6406

If you fail to submit an acceptable PoC by the due date, we may recommend (to the CMS Regional Office) termination of your provider agreement [42CFR488.456(b)(1)(ii)].



#### Optional Denial of Payment for New Admissions (ODPNA)

Based on deficiencies cited during this survey, and as authorized by Centers for Medicare & Medicaid Services (CMS) Dallas Regional Office, this is formal notification of Optional Denial of Payment for New Admissions (ODPNA). ODPNA will start August 5, 2021. Your State Medicaid Agency will be notified by copy of this letter. The CMS Regional Office will notify your Medicare payer. The Medicare and Medicaid programs will make no payment for residents admitted on or after the ODPNA effective date. ODPNA will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.]

### **PROPOSED Remedies**

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, we will provide you with a separate formal notification of that determination.

Based on the findings of noncompliance the Oklahoma State Department of Health is recommending that the following penalties be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office:

- DENIAL OF PAYMENT FOR NEW MEDICARE/MEDICAID ADMISSIONS: We are recommending a discretionary Denial of Payment for New Admissions (DPNA) effective August 5, 2021 in accordance with the statutory provisions at 1819(h) and/or 1919(h) and the federal regulation at 42 CFR 488.417(b).
- **TERMINATION OF PROVIDER AGREEMENT** if the facility is not in substantial compliance within six months after this inspection.
- Civil Money Penalty: In accordance with CMS enforcement policies, a Civil Money Penalty (CMP) is recommended for the deficiencies cited during the July 1, 2021 survey. The CMS will notify you if a CMP is imposed, the amount of the CMP, and the dates the CMP is in effect. The CMS will notify you of your rights for all remedies that are imposed.

#### Filing An Appeal

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of Nurse Aide Training and Competency Evaluation program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U. S. Department of Health and Human Services,



Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, *et seq.* You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). A written request for a hearing must be filed no later than September 18, 2021 (60 days from the date of receipt of this letter). Such written request should be made directly to:

U. S. Department of Health and Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

If you prefer, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System (DAB E-File) website: <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a>. When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The email address and password given during registration must be entered on the login screen at: <a href="https://dab.efile.hhs.gov/user\_sessions/new">https://dab.efile.hhs.gov/user\_sessions/new</a> to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the File New Appeal link on the Manage Existing Appeals screen; then b) clicking Civil Remedies Division on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59 p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at <a href="https://dab.efile.hhs.gov/appeals/to\_crd\_instructions">https://dab.efile.hhs.gov/appeals/to\_crd\_instructions</a>.

In addition, please forward a copy of your request to:



CMS Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Survey and Certification
ATTN: Leena Volmer
1301 Young Street; Room 827
Dallas, Texas 75202

## Additional Triggers for Loss of Approval of Nurse Aide Training and Competency Evaluation Program (NATCEP) and Competency Evaluation Program (CEP)

Please note that §1919(f)(2)(B) also prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Competency Evaluation Programs (CEP) offered by or in any facility which within the previous two years:

### 42 CFR §483.151(b)

- (2) The State may not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years—
- (i) In the case of a skilled nursing facility, has operated under a waiver under section 1819(b)(4)(C)(ii)(II) of the Act;
- (ii) In the case of a nursing facility, has operated under a waiver under section 1919(b)(4)(C)(ii) of the Act that was granted on the basis of a demonstration that the facility is unable to provide nursing care required under section 1919(b)(4)(C)(i) of the Act for a period in excess of 48 hours per week;
- (iii) Has been subject to an extended (or partial extended) survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act;
- (iv) Has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) of 1919(h)(2)(A)(ii) of the Act of not less than \$10,697 as adjusted annually under 45 CFR part 102; or
- (v) Has been subject to a remedy described in sections 1819(h)(2)(B) (i) or (iii), 1819(h)(4), 1919(h)(1)(B)(i), or 1919(h)(2)(A) (i), (iii) or (iv) of the Act.

#### **Informal Dispute Resolution**

In accordance with 42 CFR §488.331 and §7212 of the State Operations Manual (SOM), you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire



a copy of the ODH Form 833 and the Oklahoma IDR Process for Medicare/Medicaid Certified Facilities.

The IDR request must be submitted within <u>ten</u> calendar days from receipt of the Statement of Deficiencies (CMS-2567). This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request Form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may <u>not</u> use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care (SQC) or immediate jeopardy (IJ);
- Remedy (ies) imposed by the Department;
- Alleged failure of the survey team to comply with a requirement of the survey process;
- Alleged inconsistency of the survey team in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process.

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at <a href="mailto:IDRCoordinator@health.ok.gov">IDRCoordinator@health.ok.gov</a>, telephone at (405) 426-8200.

If you have any questions, please contact me at (405) 426-8200.



Sincerely,

Katie Stagner
Digitally signed by Katie
Stagner
Date: 2021.07.21 08:30:18
-05'00'

Katie Stagner, Enforcement Reviewer/Analyst Long Term Care Protective Health Services

C: Executive Director, Oklahoma State Board of Examiners for Long Term Care Administrators

Enclosure



#### INVESTIGATIVE REPORT

Facility:

The Commons

Address:

301 South Oakwood Road

City, State, Zip:

Enid, OK, 73607

Provider #:

375488

Complaint #:

OK00056619

Investigation Date(s): 06/21-06/25/21 and 06/28-07/01/21

| ALLEGATION(S)   | S = SUBSTANTIATED  US = UNSUBSTANTIATED |
|---|---|
| 1. The facility failed to ensure medications were administered according to physicians' orders.                         | S                                       |
| 2. The facility failed to notify resident's representative or interested family with a significant change in condition. | US                                      |
| 3. The facility failed to assess and monitor residents with fractures/with a sling to prevent skin breakdown.           | US                                      |

#### ☑ Violation (s) unrelated to this complaint were also cited during the investigation.

An unannounced on-site investigation was initiated 06/21/2021 at 5:10 p.m.

A sample of five residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

### A Description of Significant Findings Related to Each Allegation is Provided Below:

**Allegation #1**: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 684 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to notify the residents' legal representative or interested family with a significant change in condition was conducted.

A review of records documented residents' legal representatives had been notified when a resident had a change in condition.

Residents were asked if staff notified their families when they had a change in condition. They all stated they did. Staff members were asked when they would notify a residents' family member. They stated they would notify them with any changes.

At the time of the investigation, there was no deficient practice related to notifying the residents' legal representative or interested family with a significant change in condition.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to assess and monitor residents with fractures/with a sling to prevent skin breakdown was conducted.

A review of records documented skin assessments had been conducted routinely. They documented no wounds had developed as a result of slings.

Residents were asked if staff assessed their skin. They all stated they did.

Staff members were asked how they ensured residents with a sling did not get skin breakdown. They stated resident skin assessments were conducted daily and as needed.

At the time of the investigation, there was no deficient practice related to the facility failing to assess and monitor residents with fractures/with a sling to prevent skin breakdown.

#### **Determination Summary and Follow-Up Action:**

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #2 and #3. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

R. Bult an

Rae Belt, RN, CHFS

Date report completed: 07/01/2021



#### INVESTIGATIVE REPORT

Facility:

The Commons

Address:

301 South Oakwood Road

City, State, Zip:

Enid, Ok, 73706

Provider #:

375488

Complaint #:

OK00056688

Investigation Date(s): 06/21-06/25/21 through 06/28-07/01/21

| ALLEGATION(S)   | S = SUBSTANTIATED  US = UNSUBSTANTIATED |  |  |
|---|---|--|--|
| 1. The facility failed to provide care as ordered by the physician. | S                                       |  |  |

☐ Violation (s) unrelated to this complaint were also cited during the investigation.

An unannounced on-site investigation was initiated 06/21/2021 at 5:10 p.m.

A sample of three residents including any identified residen, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

### A Description of Significant Findings Related to Each Allegation is Provided Below:

**Allegation #1**: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag F684 for details.

### **Determination Summary and Follow-Up Action:**

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

R Bult Rn

Rae Belt, RN, CHFS

Date report completed: 07/01/2021



#### INVESTIGATIVE REPORT

Facility:

The Commons

Address:

301 South Oakwood Road

City, State, Zip:

Enid, OK, 73706

Provider #:

375488

Complaint #:

OK00057230

Investigation Date(s): 06/21-06/25/21 and 06/28-07/01/21

| ALLEGATION(S)  | S = SUBSTANTIATED  US = UNSUBSTANTIATED |
|--|---|
| 1. The facility failed to protect residents' right to privacy. | S                                       |

#### ☑ Violation (s) unrelated to this complaint were also cited during the investigation.

An unannounced on-site investigation was initiated 06/21/2021 at 5:10 p.m.

A sample of six residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

#### A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag F583 for details.

### **Determination Summary and Follow-Up Action:**

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a followup investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

### **Other Concerns:**

Investigations were conducted related to abuse. See the Statement of Deficiencies, Form 2567, Tag F600, F607, F609, F610 and F835 for details.

ByEsper.

Thank you for bringing these concerns to our attention.

Rae Belt, RN, CHFS

Date report completed: 07/01/2021

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391

| ` '                                       |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G   | , ,                          | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|--|--|---------------------|---|------------------------------|-------------------------------|--|--|
|   |  | 375488   | B. WING             |   | 0.                           | C<br>7/ <b>01/2021</b>        |  |  |
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP COL<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706          |                              | 701/2021                      |  |  |
| (X4) ID<br>PREFIX<br>TAG                  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |  |
| F 000                                     | INITIAL COMMENTS   | 3  | F 0                 | 00  |                              |                               |  |  |
| F 580                                     | June 28th, 2021 thro Oklahoma State Dep a complaint investiga #OK00056688, OK00 and a COVID-19 Foo the facility was in cor requirements related implementing proper control practices to p transmission of COV Notify of Changes (Ir   | cused Survey to determine if inpliance with Federal to the complaint and infection prevention and revent the development and ID-19.  | F 5                 | 80  |                              |                               |  |  |
| SS=E                                      | consult with the residence consistent with his or representative(s) who (A) An accident involves in injury and his physician intervention (B) A significant charmental, or psychosode deterioration in health status in either life-the clinical complications (C) A need to alter trained to discontinuate treatment due to advocommence a new for (D) A decision to trainesident from the fact §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section. | cation of Changes. nediately inform the resident; lent's physician; and notify, ther authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or s); eatment significantly (that is, e an existing form of erse consequences, or to rm of treatment); or usfer or discharge the |                     |   |                              |                               |  |  |
| ADODATODY                                 | DIRECTOR'S OR DROVIDER   | SLIPPLIER REPRESENTATIVE'S SIGNATUR  | <u> </u>            | TITI F  |                              | (X6) DATE                     |  |  |

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.

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ' '                | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |               | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--------------------|--|---|---------------|-------------------------------|--|
|   |  | 375488   | B. WING            |  |   | ·             | 01/ <b>2021</b>               |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |  | -                  | 30                                     | TREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH OAKWOOD ROAD  1NID, OK 73706  | <u>  0776</u> | 01/2021                       |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | х                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |               | (X5)<br>COMPLETION<br>DATE    |  |
| F 580   | physician.  (iii) The facility must a resident and the resident and the resident when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must rupdate the address (ruphone number of the representative(s).  §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configurated locations that comprispart, and must specific room changes between under §483.15(c)(9). This REQUIREMENT by:  Based on record reviews determined the faphysician of a change for one (#7) of four safor notification.  The facility identified in facility.  Findings: | ded upon request to the also promptly notify the lent representative, if any, or roommate assignment (0(e)(6); or ent rights under Federal or ins as specified in paragraph decord and periodically mailing and email) and resident apply to entite a defined in the inits admission agreement agreement and instruction, including the various set the composite distinct by the policies that apply to entits different locations are in its admission. It is not met as evidenced ew and staff interviews, it acility failed to notify the entity f | F                  | 580                                    |   |               |                               |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | IDENTIFICATION NUMBER: |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|------------------------|-----|--|-------------------------------|----------------------------|
|                          |   | 375488  | B. WING                |     |  |                               | 01/ <b>2021</b>            |
| NAME OF PE               | ROVIDER OR SUPPLIER   |   |                        | 30  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>01 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                              |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     | х   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 580                    | seizures/convulsions  | olan, dated 11/11/19,<br>risk for injury d/t [due to]<br>sMonitor/record time and   | F                      | 580 |  |                               |                            |
|                          | a.m. and again at 6:0 documentation the p either seizure.  On 06/28/21 at 2:45  | tes, dated 02/06/21,<br>dent had a seizure at 4:00<br>06 a.m. There was no<br>hysician had been notified of<br>p.m., the administrator was<br>n was notified of the seizure<br>d it didn't look like it                 |                        |     |  |                               |                            |
| F 583<br>SS=E            | stated the physician Personal Privacy/Co CFR(s): 483.10(h)(1) §483.10(h) Privacy at The resident has a riconfidentiality of his records. §483.10(h)(l) Personaccommodations, metelephone communicand meetings of familiar does not require private room for each §483.10(h)(2) The faresidents right to per | and Confidentiality. Ight to personal privacy and or her personal and medical all privacy includes edical treatment, written and cations, personal care, visits, ily and resident groups, but the facility to provide a | F                      | 583 |  |                               |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NI IMBED:   |                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |                 | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--------------------|---|--|-----------------|-------------------------------|--|
|   |   | 375488   | B. WING            |   |  | C<br>07/01/2021 |                               |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   | 510.00   |                    | S<br>3                                  | TREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH OAKWOOD ROAD  1NID, OK 73706   | <u>  077</u>    | 01/2021                       |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                 | (X5)<br>COMPLETION<br>DATE    |  |
| F 583   | the right to send and mail and other letters materials delivered to including those delivered than a postal service.  §483.10(h)(3) The result and confidential personal and media provided at §483.70(if federal or state laws.  (ii) The facility must a Office of the State Lo to examine a resident administrative records law.  This REQUIREMENT by:  Based on record reviews determined the facility in privacy was one sampled resident privacy.  The facility identified if facility.  Findings:  Resident #1 was admincluded Parkinson's | communications, including promptly receive unopened packages and other the facility for the resident, and the facility for the resident, and the red through a means other sident has a right to secure onal and medical records. The right to refuse the release cal records except as (2) or other applicable.  Illow representatives of the regression of the r | F                  | 583                                     |  |                 |                               |  |

|  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  |  | (X3) DATE SURVEY<br>COMPLETED   |   |
|--|--|--|--|--|---|---|
|  |  |  | _  |  | С   |   |
|  | 375488   | B. WING  |  |  | 07/   | 01/2021   |
| ROVIDER OR SUPPLIER  |  |  | S  | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |   |
| MONS   |  |  |  |  |   |   |
|  |  |  | E  | NID, OK 73706  |   |   |
| (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL   | 1  |  | •  |   | (X5)<br>COMPLETION<br>DATE  |
| documented, "Alleg posting a video of a remembers personal so started [and] in process A document, titled "Fit 06/12/21, documented reportedstaff membher shoe for her and spersonal Snap Chat so On 06/29/21 at 11:12 was asked how the faprivacy. She stated boto anyone that doesn' was asked if the resid when a video was tak "No."  Free from Abuse and CFR(s): 483.12(a)(1)  §483.12 Freedom from Exploitation The resident has the inneglect, misappropria and exploitation as defincted but is not limic corporal punishment, any physical or chemit treat the resident's message with the state of the stat | ation of a staff member esident on the staff cial media. Investigation ss"  nal State Report," dated d, "an incident was er recorded [resident] tying she posted the video on her story"  a.m., the director of nurses cility protects the resident's sy not giving any information thave a right to see it. She lent's privacy was protected en of him. She stated,  Neglect  m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  y must- e verbal, mental, sexual, or oral punishment, or   |  |  |  |   |   |
|  | Continued From page documented, "Alleg posting a video of a remembers personal so started [and] in process A document, titled "Fii 06/12/21, documented reportedstaff membher shoe for her and spersonal Snap Chat so On 06/29/21 at 11:12 was asked how the faprivacy. She stated be to anyone that doesn' was asked if the resid when a video was tak "No."  Free from Abuse and CFR(s): 483.12(a)(1)  §483.12 Freedom from Exploitation The resident has the inneglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemit treat the resident's message should be should b | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 documented, "Allegation of a staff member posting a video of a resident on the staff members personal social media. 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This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced | CORRECTION  IDENTIFICATION NUMBER: A BUILDI 375488 B. WING.  ROVIDER OR SUPPLIER  MONS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 documented, "Allegation of a staff member posting a video of a resident on the staff members personal social media. 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OF TAYOUT ANY OF LAND OF CORRECTION (EACH OPENCIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 (COCCUMENT AND ANY OF CORRECTION OF THE APPROPRIATE DEFICIENCY)  Continued From page 4 (COCCUMENT AND ANY OF CORRECTION OF THE APPROPRIATE DEFICIENCY)  Continued From page 4 (COCCUMENT AND ANY OF CORRECTION OF THE APPROPRIATE DEFICIENCY)  Continued From page 4 (COCCUMENT AND ANY OF CORRECTION OF THE APPROPRIATE DEFICIENCY)  Continued From page 4 (COCCUMENT AND ANY OF CORRECTION OF THE APPROPRIATE DEFICIENCY)  A document, titled "Final State Report," dated 06/12/21, documented," an incident was reported., staff member recorded [resident] bying her shoe for her and she posted the video on her personal Snap Chat story"  On 06/29/21 at 11:12 a.m., the director of nurses was asked how the facility protects the resident's privacy. She stated by not giving any information to anyone that doesn't have a right to see it. 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| AND BLAN OF CORRECTION IDENTIFICATION NUMBER |  | 1 ' '  | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED   |                   |
|--|--|--|---------------------|--|-------------------|
|  |  | 375488   | B. WING             |  | C<br>07/01/2021   |
| NAME OF P                                    | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                                | 1 01/01/2021      |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION |
| F 600  | situation was determ facility's failure to ens #9) were free from al A staff member alleg refusing/withholding #9. The allegation wadministrator and a t not conducted. The eduring the investigati against the nurse.  An allegation of staff resident #7 on 02/22 02/23/21, one day af The residents were remember was allowed. The facility documen being physically abust reported by staff. The resident, complete a implement corrected abuse.  Resident #8 made at on 06/28/21 and the continue to work ove allegation was made. Staff witnessed verbal an employee and reported to the act thorough investigation residents were not personal regions and residents were not personal regions. | mediate Jeopardy (IJ) ined to exist related to the sure residents (#5,6,7,8, and ouse.  ed that LPN #3 had been pain medications to resident as not reported timely to the horough investigation was employee remained working on and no action was taekn  being verbally abusive to /21 was not reported until ter the allegation occured. For the towork.  ted an incident of resident #5 sed by staff witnessed and e facility failed to protect the thorough investigation and measures to prevent further  an allegation of rape by staff staff had been allowed to r six hours after the  all abuse to Resident #6, by corted it. The allegation was dministrator timely and a n was not conducted. The rotected due to the g at work and continued to | F 60                |  |                   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ` ′  | E CONSTRUCTION      | COMPLETED  |                 |  |
|---|---|--|---------------------|--|-----------------|--|
|   |   | 375488   | B. WING             |  | C<br>07/01/2021 |  |
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS   |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                              | 07/01/2021      |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION   |  |
| F 600   | At 11:04 a.m., the 0 Health (OSDH) wa existence of the IJ  At 11:28 a.m., the onotified of the IJ.  An acceptable, amprovided by the adp.m. It documente  "Plan of AMENDED THESE items will be 2021 [By 8:00 p.m. Misappropriation Ir updatedAn outsid in-service on PRN administration for 0 30th. This inservice withholding medical been in serviced, by ADON [assistant doutside agency. D 06/28/21 [staff nam [CNA #6] and [LPN 06/30/21  An ADMINISTRATI the INCIDENT RESIAND INCIDENT    | Oklahoma State Department of s notified and verified the situation.  Administrator (ADM) was  ended plan of removal was ministrator on 06/29/21 at 7:20 d the following:  O Removal for IJ's - ALL be completed by June 30th, and Surange of June 30th, and Nursing on June ewill focus on neglect, and not attions. All staff that have not a June 30th, 8pm may not work at the DON [director of nursing], arector of nursing], or the sue to further consideration on the deleted] was terminated.  WE team was formed called SPONSE TEAM on June 29th, dministrator, Assistant I, ADON, and HealthCare ervices Director. The signee will report to Board of tion of abuse at regularly   | F 60                |  |                 |  |
|   | administration for C 30th. This inservice withholding medical been in serviced by until in serviced, by ADON [assistant di outside agency. D 06/28/21 [staff nam [CNA #6] and [LPN 06/30/21  An ADMINISTRATI the INCIDENT RES and includes the Administrator, DON Center Resident seadministrator or de Director any allega scheduled monthly INCIDENT responsion an outside source of the service of the | cMA, and Nursing on June e will focus on neglect, and not attions. All staff that have not by June 30th, 8pm may not work by the DON [director of nursing], by the DON [director |                     |  |                 |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY COMPLETED |                            |
|---|--|--|---------------------|---|----------------------------|----------------------------|
|   |  | 375488   | B. WING _           |   |                            | C<br>07/01/2021            |
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS   |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706             | <b>.</b>                   | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>IR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 600   | on 06/30/21 with an always protect our response team will respond to allegation investigation has been interviewed an information related administrative staff able to state accurabuse and neglect. The immediate jeon of 06/30/21 at 5:10 plan of removal and had been implement remained at a level. Based on observatit was determined to residents were free six (#1, 5, 6, 7, 8 and residents reviewed facility also failed to ensured staff were abuse and negelect. The facility identified facility.  Findings:  An employee hand documented, "The preventabuse by the sign of the sign | citing, and reporting/response dvanced traing on Abuse. To residents, the INCIDENT meet to collaborate and ons to ensure all thorough een completed."  PNs, one RN and three CMAs and able to state accurate to abuse and neglect and five were interviewed and were ate information related to advantable to a state accurate to abuse and neglect and five were interviewed and were ate information related to a p.m. when all elements of the did the amended plan of removal and the amended plan of removal and the actual harm at a pattern.  It ion, record review, interviews, the facility failed to ensure a from abuse and neglect for and #9) of six sampled for abuse and neglect. The period have an environement that free to report allegations of without fear of retaliation.  In the deficient practice of abuse and neglect. The period and the properties of the properties and the properties of the properties and the properties of the p | F 6                 |   |                            |                            |

| AND DLAN OF CORRECTION IDENTIFICATION NUMBER |   | ' '   | PLE CONSTRUCTION  G | (X3  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---------------------|--|-------------------------------|----------------------------|
|  |   | 375488  | B. WING             |  |                               | C<br>07/04/2024            |
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS    |   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | <u> </u>                      | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| F 600  | regardingabuseT retaliation, in any form making a report, comfaithAbuse & Negle ABUSE OR NEGLEC MUST BE REPORTE IMMEDIATELYFAIL OR NEGLECT, EVEINEGLECT, LEAVES THE SITUATIONBut Commons will not, in or harassing behavior violation of this policy including termination and/or harassment: Verbalridiculinghut voice at in individual Cell PhonesCell pht time onlyCode of ChroceduresViolation rulesmay result in our to and including dabuse of the resident or mental abuse by the MediaEmployees in confidentialabout not disparage any performed within 2 hours and to other officials law. Allegations that reported within 2 hours be thoroughly investifurther potential abus progressappropriational including report to the including report report report report re | the Company strictly prohibits in, against any individual splaint, or inquiry in good set PolicyNO FORM OF CT IS TOLERATED AND ED LURE TO REPORT ABUSE IN SUSPECTED ABUSE OR YOU RESPONSIBLE FOR callying & HarassmentThe ay instance, tolerate bullying instance, tolerate bullying in Employees found in will be disciplined, up to andexamples of bullying camiliatingShouting, raising in publicTelephone Calls & one use is limited to break onductDisciplinary in sof any of these corrective action being taken, ischargePhysical or mental is or failure to report physical thersSocial | F 60                |  |                               |                            |

| AND DUAN OF CORRECTION IDENTIFICATION NUMBER |   | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  IG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|-----------------------|---|-------------------------------|----------------------------|
|  |   | 375488   | B. WING _             |   |                               | C<br>07/01/2021            |
| NAME OF P                                    | ROVIDER OR SUPPLIER   |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                 | •                             | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>IR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 600  | abuse, neglectAll upon first employm thereafter, regardin abuseImmediatel abuse, neglect or n supervisorThe suphone of the ADMII DONSuspected also be reported to state agencies, law families, and/or ressubject of abuse sh discussedInvestig for, treat and PROTADON, or house suassessment immedin detailTake a stresident2ndIsolImmediately notif"  1. Resident #9 had chronic pain and os A resident assessment documented the remoderately impaired A care plan, effectiv "Resident is at rismuscle spasms and syndromeReside treated/relieved in a medications as pre Physician's orders, "hydrocodone 7.5 rismuscles and syndrome 7.5 rismuscles and syndrome 7.5 rismuscles orders, "hydrocodone 7.5 rismuscles or the property of the proper | In resident will be free from a facility staff will be in-serviced ent, and at least annually ingneglect or any report any suspicion of instreatment to your immediate apervisor WILL CALL the CELL INISTRATOR [admin], then the for substantiated cases must are respective agencies such as a renforcement, physician; ident responsible party. The intellibe routinely and openly grationProcedure1stCare in increase in the perpetrator3rd in the perpetrator3rd in the perpetrator3rd in the perpetrator3rd in the perpetrator, then DON in the diagnoses which included in the perpetrator | F 6                   |   |                               |                            |

|                          | OF DEFICIENCIES  CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′   | PLE CONSTRUCTION   | , ,        | COMPLETED                  |
|--------------------------|---|--|---|--|------------|----------------------------|
|                          |   | 375488   | B. WING   |  |            | C<br><b>07/01/2021</b>     |
| NAME OF PR               | ROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706 |  | 07/01/2021 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | IOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 600                    | Tylenol 325 mg cal route every 6 hours.  Ultram 50 mg table route every 6 hours.  A statement from C 12:35 a.m., docum multiple occasions, in the morning afte [Resident #9] get u ask for a pain pill. Norco and rate his butt pain. As proto request to the char go to the resident to report back to me, administer a pain in level of the pain the location of th [sic] p [LPN #3], will deny name], pain meds a doesn't need a pain smoke a cigarette, he can go outside to on these occurance pain meds until sor | eeded FOR CHRONIC PAIN  psule give 2 tablets by oral as as needed for pain  t give 1 tablet (50 mg) by oral as needed for pain"  EMA #3, dated 06/26/21 at ented, "Generally everyday, on typically beginning first thing the CNA has helped pout of bed for the day, he will He will specifically ask for a pain at an 8 out of 10 for leg or col, as the CMA, I report the ge nurse, the charge nurse will be evaluate the resident and the CMA, with guidance to need and instruct me with the lat was reported and the vain. On many occurances, the resident, [Resident's estating 'He just got up, he in pill' or 'He's going outside to he's not hurting bad enough if to smoke' or 'He can't have a le hasn't eaten anything yet.'  es, [Resident] won't receive metimes 10 a.m or as late a 2 in the MAR [medication] | F 60  | ,  |            |                            |
|                          | An OSDH incident<br>documented, "[R<br>Abuse/Mistreatmer<br>IncidentStaff repo<br>pain meds when re   | form, dated 06/26/21,<br>esident #9]Allegations of   |   |  |            |                            |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  |           | ATE SURVEY<br>DMPLETED     |
|--------------------------|--|--|-------------------------|--|-----------|----------------------------|
|                          |  | 375488   | B. WING _               |  |           | C<br><b>07/01/2021</b>     |
| THE COM                  | ROVIDER OR SUPPLIER  |  | 1                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706          |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG     | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | 12:23 [did not docur documented, "Some pills when it is not tir is scheduled [every] offered Tylenol if No Safe surveys were of The questions asked related to receiving proceed to the facility document unsubstantiated and 5:30 p.m.  The employee continuestigation of the another the alleged of the facility did not convestigation and introduce the alleged of medications being with the conclusion of the invadministrator stated spreadsheet of which versus the Norco. Shad administered the other nurses. She will documentation of the surveys the Norco of the conclusion of the conclusion of the invadministered the other nurses. She will documentation of the conclusion of the co | PN #3, dated 06/27/21 at ment a.m. or p.m.], stimes resident asks for pain me as he had it earlier. Med 8 [hours] prn. Resident is rco can't be given yet"  conducted with five residents. It to the residents were not pain medications.  Inted the allegation was 1 completed on 06/27/21 at mued to work during the lleged negelct.  Complete a through erview residents and staff to victim regarding pain | Fé                      | 600  |           |                            |
|                          | asked if there was n resident requested it   | he had requested it. She was o documentation of when the t and the CMA stated LPN #3 tion, how did they come to the  |                         |  |           |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  IG  |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|---------------------|--|-----------|----------------------------|
|                          |  | 375488  | B. WING _           |  |           | C<br><b>07/01/2021</b>     |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706              |           | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | conclusion the allegal She stated she went him about it. She staturse's biggest chee At 1:19 p.m., the ADI There were no quest related to staff withhe stated the executive surveys and thought members respect you make decisions regal that.  On 06/29/21 at 6:35 if he was in pain. He right side, leg and known rate it at an 8 out of a 9 in the mornings. he did not get his Nordestated, "If I don't was asked if his Nordestated it was and the disclose who the emmedication.  At 7:02 p.m., CMA # allegations made regoneror. She stated, "the time." She stated when he asks for sor have to follow." She give the same responsitatement. She stated their pain as they stated would have her administead of the Norco. | ation was unsubstantiated. to the resident and asked ated the resident is this rleader.  M provided resident surveys. ions asked to the residents olding pain medications. She director had made the that the question "Do staff ur requests and allow you to rding your care" covered  p.m., the resident was asked a stated he had pain in his ee. She stated he would 10. He stated it was usually He was asked how he felt if the roo when he requested it. If the powas ever withheld. He is the provided he would not ployee was that witheld the sarding LPN #3 withholding Norco is what he asks for all did, "It's upsetting to me cause mething, I have protocol I stated that LPN #3 would have CMA #3 had put in her ed she was taught to take ted it. She stated LPN #3 nister Tylenol or Ultram | F6                  |  |           |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION IG   |           | OMPLETED                   |
|--------------------------|---|---|-------------------------|--|-----------|----------------------------|
|                          |   | 375488  | B. WING _               |  |           | C<br>07/01/2021            |
| NAME OF PR               | ROVIDER OR SUPPLIER   |   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706              |           | 3170 H202 I                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | anxiety disorder.  A quarterly resident documented the resimpaired.  A state incident report documented, "IncidentAdministrational legation of verbal from a staff member is not on the schedunot be working until investigated. Investigated and final reports of the investigationimplemented to prevattached for investigated. | assessment, dated 02/18/21, ident's cognition was severely ort form, dated 02/23/21, dent TypeAllegations of  | F 6                     |  |           |                            |
|                          | Employee Assistance The allegation of ab admininistraor until to admininistraor until to within two hours to the asthe Oklahoma St. (OSDH).  A written statement documented, "The component a majority of the hallway outside of [a approximately 2 p.m. himself in his wheeled.)   | urnout. Also gave her the information"  use was not reported to the the next day after it occured.  report the allegation of abuse he appropriate agencies such ate Department of Health  by CMA #3, dated 02/23/21, lay of 2-22-21, [resident #7] he day sitting in the North Hall another resident]s room. At i. [resident #7] wheeled chair up closer to the nurse's ked himself in his wheelchair |                         |  |           |                            |

| AND DIAN OF CORRECTION IDENTIFICATION NUMBER |   | ` '  | PLE CONSTRUCTION  G | , ,  | (X3) DATE SURVEY COMPLETED |                            |
|--|---|--|---------------------|--|----------------------------|----------------------------|
|  |   | 375488   | B. WING             |  |                            | C<br>07/01/2021            |
| NAME OF P                                    | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          |                            | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |
| F 600  | and yelled to [resider here, you're not goin here." [Resident #7] yelled at [LPN #3]. I at her, his speech is to health conditions. again "get the hell out talk to me that way." [resident #7] wheeled nurse's station area his roomDuring this sitting in a chair besientire event"  A written statement is documented, "On Mo #4] came into work I sitting at nurses static came strolling up to nurses station [LPN around and go back said I dont care Im nand he said he wanted screamed at him and your [sic] not sitting to deal with your Ass. so Corner til [LPN #3] led of the evening"  A written statement is documented, "The or getting something what [resident #7] started #3] got louder and to | rege nurse's office. rege nurse, [LPN #3], stood up nt #7] "get the hell out of g to sit up here while I'm did raise his hands and do not know what he yelled often hard to make out due [LPN #3] then yelled at him at of here, you're not going to After this occurrence, d himself away from the back down the hall towards a occurrence, [CMA #4] was de me and witnessed the  by CMA #4, dated 02/24/21, anday February 22nd I [CMA awas on North Hall. I was on [resident #7] the resident the Common Area by the #3] the nurse told him to turn the said he has rights She of gonna [sic] deal with you and to sit up here She I said "I dont give a dam [sic] up here Im not gonna [sic] to [resident #7] sat in the aft he was very upset the rest by CNA #3, dated 02/24/21, ther day I was in the office then I heard [LPN #3] yelling telling him to go to his room. I yelling back at her and [LPN Id him she wasn't going to ur room. [LPN #3] then said | F 60                |  |                            |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  IG  |           | OMPLETED                   |
|--------------------------|--|---|---|--|-----------|----------------------------|
|                          |  | 375488  | B. WING _   |  |           | C<br>07/01/2021            |
| NAME OF P                | ROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706 |  | •         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG   | PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | Continued From pag   |   | F6  | 00   |           |                            |
|                          | 5:00 p.m., documen [administrator (admi back [and] was told against me for yellin Monday February 2: [approximately] [2:00 the man but suppos [admin] via the came told I told male resided hall or go to his roor to sit in the area by it congests the hallow towards the resident would like to happenedResident sitting near the nurs came down the hall leave the deskWh resident(s)? Was the resident has had our eason a staff member should like to happen shoulderWhen did 2pm on Feb [Februa supervisory/manage about the incident | op.m.]Not only did I yell [at] edly I cussed [at] him also per eras. No AudioWas also ent to go away, go down the n. I had asked residents not wound care Nurse's office as rayMay of raised my voice i"  mary, undated, documented, ported victim[resident reported perpetrator[LPN I the incident[CMA #3],What twas in his wheelchair e's desk. [LPN #3] the nurse and started yelling at him to at is the history of the e incident foreseeableThe threaks lately, but there is NO per should yell at a resident, but it foreseeableWhat does the en[resident #7] would not but when asked what he in, he just shrugged his the incident happenAround ary] 22ndWhen was facility ement staff first contacted |   |  |           |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|----------------------------|
|                          |  | 375488  | B. WING            |     |  |                               | C<br>01/2021               |
| NAME OF PR               | ROVIDER OR SUPPLIER  |   | 1                  | 3   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>801 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                            |                               | V 1/2 - 1                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 600                    | Name: [LPN #3]Did or Criminal Behavior. abuseDescription or suspended pending the returned to work on 0 disciplinary action write a resident and for concontrary to recognize employment at the factor of the administrator and the facility failed to provide abuse during the investment of the administrator and not completed.  On 06/23/21 at 2:24 provides to describe the incide 02/22/21 with resident resident is hard of he didn't yell. She stated took statements from and discussed the incide o2/22/21. She was asked when the incide stated she was notified was asked what the cownite up. She was asked write up. She was asked write up. She was asked when the she was asked when the she was asked when the she was asked what the cownite up. She was asked write up. She was asked write up. She was asked when the she write up. She was asked write up. She was asked when the she write up. She was asked when the she write up. She was asked write up. She was asked when the she write up. She was asked write up. She was asked write up. She was asked when the she write up. She was asked write up. She was asked write up. | /21, documented, "Nurse's incident include MisconductYes: Patient f InvestigationLPN was the investigation and 2/26/2021. She received te up for raising her voice at inducting herself in a manner d standards. Her cility is being retained"  Deriod from 02/14/21 to d LPN #3 worked til 6:48 en #3 worked approximately es after the abuse occurred.  Protect residents from further estigation.  Proof the allegation timely to a through investigation was entered that happened on entered | F                  | 600 |  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |   |           |                            |
|--|---|--|-------------------------------|---|-----------|----------------------------|
|  |   | 375488   | B. WING _                     |   |           | C<br>07/01/2021            |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706             |           | 0170172021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600  | done to protect and to other residents. Sanything else other was asked who the abuse to. She state asked when the staff did they report timely asked if the staff whinserviced about rep "Nothing in writing."  On 06/24/21 at 1:09 verbal abuse happe p.m. She stated "Ye continued to work at was asked if LPN #3 residents, how were stated," They couldr about it." She was a report the abuse importected. She state The ADM was asked after the incident. So The staff members worked with the victi approximately four holds a policy of the will allegation of verbally The facility substant | "She was asked what was prevent this from happening She stated they didn't add than what was in place. She staff can report suspected d, "Any authority." She was f had witnessed the abuse, y. She stated, "No." She was o witnessed the abuse were porting timely. She stated,  p.m., the DON was asked if ned on 02/22/21 around 2:00 as." She was asked if LPN #3 after. She stated, "Yes." She continued to work with the resident protected. She after be because we didn't know asked, since the staff failed to mediately, were the residents and if the resident was assessed the stated, "No."  If if the resident was assessed the stated, "No."  who witnessed the abuse did out it. As a result, LPN #3 m and other residents for nours and 48 minutes.  ut any corrective measures in use from reoccurring. As a anesses [CMA #4] had an a abusing a different resident. inted allegation and while LPN #3 continued to be | F6                            |   |           |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | PLE CONSTRUCTION  G   |          | DATE SURVEY<br>COMPLETED   |
|--------------------------|---|--|---------------------|---|----------|----------------------------|
|                          |   | 375488   | B. WING             |   |          | C                          |
| NAME OF P                | ROVIDER OR SUPPLIER   | 1 010400   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                       | I        | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | 3. Resident #5 was a diagnoses which income A quarterly resident adocumented the residaily decision making. An initial incident republication of the following and initial incident republication of the following and initial incident of the following and initial incidentReceived a towards a resident be member suspended. A written statement of 106/07/21, documented and following asked me if I couyes just give me a semiddle of taking cared I walked into [resident ahold [sic] of his Rigon him while she was bare skin I yelled a way [and] she was lidropped him back on his arm to get him up would take care of his arm to get him up would take care of his eakfast [and] told to just happened. When #2] she told her to stop [10:00 a.m.] I asked [and] I told [DON] when she was not away asked me to write out. | admitted to the facility with luded dementia.  assessment, dated 05/02/21, dent's cognitive skills for g was severely impaired.  ort form, dated 06/07/21, identInvolved[resident Allegations ofDescription of an allegation of abuse y staff member. Staff pending investigation"  from CMA #2, dated ed "Around [8:30 a.m.] [CNA ald come help her I told her econd because I was in the e of another Resident. When in #5]'s room [CNA #2] had the arm yanking [and] pulling is slapping at his left leg,-on at her to stop doing him that ke what [and] just kind of in the bed, she went to pull on the bed, she went to pull on the Charge Nursewhat had in [LPN #2] talked to [CNA ay away from direct care of I seen [sic] D.O.Naround if [LPN #2] had talk to her nat had happened She told re but now she is [and] | F 61                |   |          |                            |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |            | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---|---|------------|-------------------------------|--|
|                          |  | 375488  | B. WING   |   |            | C                             |  |
| NAME OF PR               | ROVIDER OR SUPPLIER  | 373400  | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706 |   | 07/01/2021 |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE    | (X5)<br>COMPLETION<br>DATE    |  |
| F 600                    | me to help get him [r room where she was at her states she saw at his left leg so I told finish him, I went to [happened she said I never hurt anyone w room"  A written statement f documented, "[residesided [sic] to get him was getting him dreshis pull-up on the [sidesided for put his arm went to put his head me. got his head in t shirt down. tried to son leg to Push Leg ir have my other hand him sit up. then hold stand him to finish go was fighting me. I w [sic] him down to res [CMA #2] came in th hold him up. then to the [sic] she would g | e 19 ecause she came out to ask resident #5] up I went into the sand he was mad and hitting wher grab his arm and swat did her to leave and I would (CNA #2] and asked what was just playing and I would as told by nurse to stay out of from CNA #2, dated 06/07/21, dent #5] was awake. So im up. got his clothes ready started talking to him while used. I started by putting [sic] to then i put his pants on. cospital gown off. got his shirt in. then put the arm in as I his shirt, I told him not to Bite he whole [sic] [and] pull his sit him up By Putting my arm in a sitting position while i around upper back to help ered [sic] at [CMA #2] to help ered [sic] at [CMA #2] to help etting dressed. Because he as patting hisleg to clam ure [sic] it was ok. then eir [sic] saw i was trying to lid me Let him lay Back down et him. then said was he room and went the Break | F 6   |   |            |                               |  |
|                          | room. then the nurse her no i was patting down. [LPN #2] told until told other wise  | eask me if i hit him I told him to try come [sic] him me not go around him again" mary, undated, documented,  |   |   |            |                               |  |
|                          | #5]who isreporte   |   |   |   |            |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING |  | (X3) DATE SURVEY COMPLETED   |   |  |             |                            |
|---|--|--|---|--|-------------|----------------------------|
|   |  | 375488   | B. WING   |  | 0:          | C<br>7/ <b>01/2021</b>     |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706 |  | 1 0.1011202 |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRIDEFICIENCY) | JLD BE      | (X5)<br>COMPLETION<br>DATE |
| F 600   | yanking on Resident legWhat was done from further harmS around the resident nurse on the hall and sent home pending DONWhat is the hall the incident foresees of being combative the deliveredWhen did happen06/07/21, [supervisory/manage about the incident]  A final state report, of "A skin sweep was by two nurses with reduced perpetrator 06/07/2021 pending 06/08/2021 she was the Administrator. So or what could be contained as the Administrator of what could be contained as completed a Redunderstanding Dem perpetrator was allow 06/08/2021"  CNA #2's time sheet documented she woten a.m. to 10:04 a.m., at a.m. and on 06/08/2 and from 1:57 p.m. to the facility had documented to complete the co | dAllegation that CNA was as arm and slapping his to protect the resident(s) Staff member was told not go until further notice by the dithen was suspended and investigation by the distory of the residentWas ableResident has a history of staff when cares are dithe incident 7:30 a.m.]When was facility ment staff first contacted 10:00 a.m.]"  Idated 06/08/21, documented, a completed on the resident in injuries notedThe was suspended on an investigation. On counseled by the DON and the received verbal education insidered to be abuse. She elias Training entitled entia. The accused wed to return to work on 11:37 and from 10:36 a.m. to 11:37 and from 8:27 a.m. to 1:27 p.m., | F 60  |  |             |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  IG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|-----------------------|---|-------------------------------|----------------------------|
|  |  | 375488   | B. WING _             |   |                               | C<br>07/01/2021            |
| NAME OF P  | ROVIDER OR SUPPLIER  |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                 |                               | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 600  | to describe her inveshe would complete and suspend staff, the staff on the hall that complete safe survest the section of the hall was asked if staff was asked if staff was tated not always. So considered interview on other halls. She other staff but not of asked when the investigation stated on 06/07/21 awhen the investigation stated late on 06/07 thorough investigation stated, "I feel it was the resident was asked when she suspended and sensishe worked on 06/07/21. She state lunch and when she suspended and sensishe worked on 06/07/21. She state lunch and when she suspended and sensishe worked on 06/07/21. She state lunch and when she suspended and sensishe worked on 06/07/21. She state about dementia, she and two and a half half was asked what corplace to prevent furtiresidents. She state about dementia, she and two and a half half half half half half half ha | 8 p.m., the DON was asked stigation process. She stated an incident report, remove ake statements from other the incident occurred and bys on cognitive residents on all the incident occurred. She briked the same hall. She orked the same hall. She orked the same hall. She of the was asked if she wing other staff and residents stated she has interviewed their residents. She was estigation was started. She was completed. She was completed. She was conducted. She was asked if a con was completed. She thorough." She was asked if sessed after incident for stated, "No."  In CNA #2 had worked on ad she left at 10:04 a.m. for returned, she was thome. She was asked when 8/21. She stated she was meet with DON and watch returned to the floor. She ciplinary actions CNA #2 d she watched Relias video a was suspended on the 7th hours on the 8th. The DON rective actions were put in the abuse and protect the ed there were no changes. A didn't feel the allegation CNA #2 left the door open | F 6                   |   |                               |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| 1 1                      |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` ′                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|---|--------------------|---|--|-------------------------------|----------------------------|
|                          |  | 375488  | B. WING            |   |  | C<br>07/01/2021               |                            |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                    | S<br>3                                  | TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH OAKWOOD ROAD ENID, OK 73706                                    | 1 077                         | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 600                    | work with other reside and a half to two and investigation was not interviewing other statit is unknown if other involved.  4. Resident #8 had dopressure ulcer to the vacuum (vac) and path documented she work a.m.  A time record for CNA documented she work a.m.  A progress note, date documented, "She she was raped by 50 minutesStaff is not themselves. This was per policy"  On 06/28/21 at 5:20 a observed to be at the When approached, that a call that a resident I They were asked whe call. One stated, "Ab | y manner.  I incident to the DON result, CNA #2 continued to ents for approximately one a half hours. A thorough completed by not ff and residents. As a result, residents had been  iagnoses which included sacrum requiring a wound in.  #2, dated 06/27/21, ked from 5:33 p.m. to 5:39  A #5, dated 06/27/21, ked from 10:01 p.m. to 5:39  ad 06/28/21 at 4:23 a.m., than [sic] began saying that females every 30 | F                  | 600                                     |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '   | E CONSTRUCTION      | (X3) DATE SURVEY COMPLETED  |                 |
|---|--|---|---------------------|---|-----------------|
|   |  | 375488  | B. WING             |   | C<br>07/01/2021 |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | ;                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                               | 1 01/01/2021    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETION |
| F 600   | lady who says she with the two ladies home.  An OSDH incident of documented, "Fin of Abuse/Mistreatm IncidentResident being raped by 50 p was also saying we when staff CMA gay [signs/symptoms] of day and final report of the investigation.  A report summary, completion 06/28/2"Who is/are the rewoman and 50 of the happenedAccusa bugsWhat was dofrom further harm room 2 at a timeV of the incidentNot the resident's currer statusAssessmen 06/28/21When was supervisor/manage about the incident  A statement from R "2305-2315 [11:00 began saying that the bed was check sign of bugs. She to she was raped. She allegations. She sawoman and there is She can not really of the statement from the same contact of the sa | was raped and I didn't send e."  report, dated of 06/27/21, al[Resident #8]Allegations entDescription of makes allegation that she was beople every 30 minutes. She were trying to poison her we her ultramNo S/S f physical rape notedFor 5 s, please include a summarySee attached  date and time of report 1 at 5:10 p.m., documented, eported perpetrator(s)A memWhat tion of Rape and bed one to protect the resident(s) Staff was to always go in What was done upon discovery ified AdministratorWhat is nt physical t done at 5PM as facility ment staff first contacted 11:47 PM [06/27/21]" | F 600               |   |                 |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION  NG   |   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|---|---|----------------------------|
|                          |  | 375488   | B. WING _           |   |   | C<br><b>07/01/2021</b>     |
| NAME OF P                | ROVIDER OR SUPPLIER  | I  |                     | STREET ADDRESS, CITY, STATE 301 SOUTH OAKWOOD ROAD ENID, OK 73706 |   | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ( (EACH CORRECTIV<br>CROSS-REFERENCE                              | AN OF CORRECTION<br>/E ACTION SHOULD BI<br>D TO THE APPROPRIA<br>(CIENCY) | 5.475                      |
| F 600                    | in with 2 Licensed nu  A statement from CN 12:32 p.m., documer #8] started yellingS yelling rape. She sai everyone has been ra been raped every 30  A statement, dated 00 documented, "Reside abused and raped re  A statement, dated 00 documented, "On 6 [resident #8's room n Rape multiple times a coming"  On 06/28/21 at 6:27 a had received a text m nurse last night at 11 resident's wound vac was observed to be r from the charge nurse when the nurse went resident alleged rape the nurse had informe to go in there alone. told the nurse to go a get a description of w The nurse told the AL female rapist and 50 The charge nurse told "looks like us." | tration we have been going rses"  A #5, dated 06/28/21 ay nted, "At 11:14 pm [Resident hortly after she started d she was raped and that aped. She said that she has minutes by 50 people"  6/28/21, from CNA #7, ent stated she was being | F6                  | 500   |   |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` ′  | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED  |                   |
|---|--|--|---------------------|--|-------------------|
|   |  | 375488   | B. WING             |  | C<br>07/01/2021   |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                              | 07/01/2021        |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION |
| F 600   | the family and physic resident. She state assessed. The adrinurse, "You can't raclose to." She was that had been work stated it was a CNAThe ADM was asked residents once she allegation of rape. with two, always two facility policy was forwas an allegation of find the policy." She reading it. She stated, "I don't She was asked when she stated, "I don't She was asked if hemployees for alleg followed. She stated on 06/29/21 at 11:3 regarding resident reviewed with the Aber report on the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated of the stated of the stated of the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated of the stated of the stated of the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the report that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the reperpetrators as "loo investigative report unable to give a de "Yes", reffering to the stated her that the report that the repor | Ininstructed the nurse to inform sician and to assess the ed the resident refused to be ministrator stated she told the ape someone you can't get asked who the two staff were ing with the resident. She and an RN.  In the approximation of the she stated, "I told her to go in the she stated, "I told her to go in the she stated, "I told her to go in the she was asked what the for protecting residents if there is abuse. She stated, "Let me the located the policy and began ted, "Immediately remove the was asked if either of the suspended. She stated, "Not tated, "I came and did it later." at time she suspended them. know, I was with the police." the policy for suspending gations of abuse had been ed, "No." | F 60                | 0  |                   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | LE CONSTRUCTION     | (X3) DATE SURVEY COMPLETED   |                  |  |
|---|---|--|---------------------|--|------------------|--|
|   |   | 375488   | B. WING             |  | C<br>07/01/2021  |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                                | 1 07/01/2021     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION |  |
| F 600   | say." Reviewed her she stated the nurse description the reside the report document describe the perpetragiven.  The two employees facility all night after resident identifying the who raped her.  The facility failed to him to the facility failed him to the failed failed failed him to the failed him | stated, "What does the report interview from yesterday that reported to her the ent stated "looks like us" and ed the resident was unable to ator. There was no response remained working at the the allegation of rape and the ne RN and CNA as the ones have an accurate a through allegations.  Itiagnoses which included e.  ent, dated 02/15/21, dent's cognition was intact.  03/21/21, documented LPN a.m. to 3:21 p.m.  103/21/21 at 1:44 p.m., ent observed on floor lying on the lent report, dated 03/21/21, gations of Abuse | F 60                |  |                  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED         |                            |
|---|---|---|---------------------|---|---------------------------------------|----------------------------|
|   |   | 375488  | B. WING _           |   |                                       | C<br>07/01/2021            |
| NAME OF PI  | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                 | · · · · · · · · · · · · · · · · · · · | 0170172021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE                              | (X5)<br>COMPLETION<br>DATE |
| F 600   | Continued From pag  | e 27  | F 6                 | 00  |                                       |                            |
|   | documented the repo<br>03/22/21 at 4:22 p.m   | ort was sent to the OSDH on   |                     |   |                                       |                            |
|   |   | nentation in the resident's alleged abuse against the   |                     |   |                                       |                            |
|   | The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours.  A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m. |   |                     |   |                                       |                            |
|   |   |   |                     |   |                                       |                            |
|   | at 6:38 p.m., docume<br>day and final reports   | faxed to OSDH on 03/23/21<br>ented the followingFor 5<br>, please include a summary<br>Face Sheet attached,<br>d" |                     |   |                                       |                            |
|   | on 03/23/21. The follasked:   | onducted with three residents lowing questions were   |                     |   |                                       |                            |
|   | light, you get everyth  | nen you turn on your call<br>ing you need taken care of?<br>taff using inappropriate                              |                     |   |                                       |                            |
|   | 4. If you feel like you know who to talk to?  |   |                     |   |                                       |                            |
|   |   | were documented.  Forking after the allegation of en made and throughout the                                      |                     |   |                                       |                            |
|   |   | n staff statements from the er, the perpetrator (LPN #1) and investigation. The                                   |                     |   |                                       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                    |         | (X3) DATE SURVEY COMPLETED  |       |                            |
|---|---|--|--------------------|---------|---|-------|----------------------------|
|   |   | 375488   | B. WING _          |         |   | 1     | C<br>01/2021               |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                    | 301 SOU | ADDRESS, CITY, STATE, ZIP CODE  ITH OAKWOOD ROAD  IK 73706  | 1 011 | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | <       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 600   | the staff member may others. She docume #6. She documented reported hearing the member who had may administrator docume incident did not occur. On 06/24/21 at 1:35 g when LPN #1 worked she worked til 3:21 p did the LPN receive. She was asked wher completed. She state completed, but the dostated there was con and LPN #1. She was worked during the invistated, "Yes." She was asked, how protected if the LPN ginvestigation. She state She was asked, how protected if the LPN ginvestigation. She stre-interviewed and had the allegation could resided if was reported not notified until the resident stated she recalled She stated she did. Sursed at the resident that he had fallen. Sursed she reported if stated she | ented that she had spoken to king the allegation and three nted she spoke with resident d the only person who comments was the staff ade the allegation. The ented her conclusion was the r.  p.m., the DON was asked d on 03/21/21. She stated .m. What disciplinary action The DON stated, "None." In the investigation had been ed the investigation was ocumentation was not. She flict between the activity aide as asked if LPN #1 had westigation. The DON has asked what was put in courrence and to protect the d there were no changes. I residents had been worked during the lated the complainant was ad a discussion about how not have occurred. She was d timely. She stated she was | F                  | 600     |   |       |                            |

|   | PROVIDER/SUPPLIER/CLIA<br>DENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  IG   |          | (X3) DATE SURVEY<br>COMPLETED |
|---|--|---------------------|--|----------|-------------------------------|
|   | 375488   | B. WING             |  |          | C                             |
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS   | 010400   |                     | STREET ADDRESS, CITY, STATE, 2 301 SOUTH OAKWOOD ROAD ENID, OK 73706 | ZIP CODE | 07/01/2021                    |
| PREFIX (EACH DEFICIENCY MUST  | NT OF DEFICIENCIES<br>T BE PRECEDED BY FULL<br>ENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE CROSS-REFERENCED                                    |          | DATE                          |
| administrator.  The facility failed to protect investigation of abuse, thorallegation of abuse and fair allegation to the administrate agencies timely.  6. Resident #1 was admitted diagnoses which included A quarterly resident assess documented the resident's impaired.  A state incident report form documented, "Resident #1]Incident TypeAllegated Abuse/Mistreatment"  A notification of nurse aide 06/12/21, documented, " employee terminated Yes 06/12/2021ALLEGATION ABUSEOn June 12, 202 11:00 am a incident was remember in which a Reside involved. CNA #1 recorders shoe for her and she posted personal SnapChat story we does your resident ever tie reason??" The caption was laughing face emoji and he was terminated for mistreat violation of our facility Sociological medical story and the was terminated for mistreat violation of our facility Sociological medical story and the was terminated for mistreat violation of our facility Sociological medical story and the was terminated for mistreat violation of our facility Sociological medical story and social story and social story and social medical story and social story and social medical story and social story and soc | aurghly invesitgate an led to report the ator and approriate and to the facility with Parkinson's disease.  Sment, dated 06/12/21, cognition was severely  a, dated 06/12/21, linvolved[resident tions of  report, dated CNA #1was solutermination date approximately sported by a staff at approximately sported by a staff at [resident #1] tying her and the video on her with the caption "But your shoes for no as followed by a seart emoji. [CNA #1] thent of a resident and al Media Policy" | F6                  |  |          |                               |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ` ′  | LE CONSTRUCTION     | COMF  | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|--|---------------------|---|----------------------------|----------------------------|--|
|   |  | 375488   | B. WING             |   | l                          | C<br><b>/01/2021</b>       |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             |                            | 01/2021                    |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |  |
| F 600   | She was asked what media restrictions we anything about reside pictures. She stated cell phones in break phone in resident are the staff were inserving She stated they pland July. She stated they had to wait for the updated policy. She measures were put in residents from further they weren't.  On 06/24/21 at 2:00 what staff were intervined weren't.  On 06/24/21 at 2:00 what staff were intervined they weren't.  On 06/24/21 at 2:00 what staff were intervined they weren't.  A thorough investigation "Guess not." She was protected from further they did not initiate at A thorough investigation if any other staff or resident of the Company of the Com | e 30  If are hired during orientation. If the cell phone and social If the cell phone If the cell ph | F 60                |   |                            |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     | ' '  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|--|---|---------------------|--|-------------------------------|----------------------------|--|
|   |  | 375488  | B. WING _           |  | 0                             | C<br>07/01/2021            |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706           |                               | 770 172021                 |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 600   | When [CMA #4] said [and] retaliated agair  Staff Assigned to InvestigateADON]. 2-10 shift for 7/19/20 to confirm the above nurse and she stated her and when [reside they put a mask on higoResolution[CM discuss her allegation didn't back those alle employee warning for misrepresentation 2) manner contrary to remorality [and] decendencern form]When I refused to do anythin F words. Would thromake [CMA #4] pick every weekend she hincident happened of anonymouswants to the complex of the c | d] said "I'm tired of this shit. anything, she was bullied ast  InvestigationWatched the on camera and saw nothing complain. I talked to the dino issues were reported to ent] comes out of her room, were and let her law in a called in to as was informed the video egations up. She received an error of the law in a cacognized standards of exy[On the back of the [CMA #4] told the nurse, she ag [and] just said a bunch of withings off the desk [and] them upThis happened has workedThis specific in 7/19/20Wants to remain to be notified of resolutions"  Ig notice, dated 07/27/20, PLOYEE [CMA#4]Date of PROBLEM/EVENT/INCIDEN misrepresentation about suspension of one N:WRITTEN WARNING | F 6                 |  |                               |                            |  |
|   | misrepresentation ar   | nd dishonesty as a direct allegation of verbal abuse  |                     |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---------------------|---|-------------------------------|----------------------------|
|  |   | 375488  | B. WING _           |   |                               | C<br>07/01/2021            |
| NAME OF P  | ROVIDER OR SUPPLIER   | 1   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                 | <u>'</u>                      | 3173172321                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 600  | staff reported susper they reported it to the their chain of common months ago, a residuabuse to her and an DON was busy testimeeting so they were she stated they were chain of command. The reported to if the DO stated they can alway phone.  On 06/24/21 at 11:11 she witnessed abusmonth or two ago are She was asked when She stated staff typic of command but the abuse was her chain to state the incident She was asked if she shad ever felt like incidents of allegation. The stated, when the stated, when the stated she was hold it against her.  On 06/25/21 at 9:50 she had ever felt like incidents of allegation. She stated, when the stated she was hold it against her.  At 3:09 p.m., the act had ever felt like she of abuse. She stated | a.m., LPN #3 was asked who cted abuse to. She stated e DON because that was and. She stated, about three ent had reported verbal other nurse. She stated the ng staff, the ADM was in a at to the admin's assistant. e told they had to go to their She was asked who they N was not in the facility. She are reach her on her the cell of a.m., CMA # 3 was asked if the she stated she did a had she reported it to the ADM. In and who did she report to. cally report through the chain person who had done the nof command. She went on was "traumatizing to me." e was afraid to report abuse. worried that someone would a.m., LPN #1 was asked if the she could not report as of abuse. She stated, "Sometimes things don't get 'We feel like people should | F 6                 |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ` ′   | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED   |         |                            |
|---|--|---|---------------------|--|---------|----------------------------|
|   |  | 375488  | B. WING             |  | C 07/01 | /2021                      |
| NAME OF F   | ROVIDER OR SUPPLIER  | 1 2000  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                                  | 1 07701 | 72021                      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE   | (X5)<br>COMPLETION<br>DATE |
| F 607<br>SS=K   | On 06/28/21 at 3:20 #1 and ADM were as investigation related 07/24/20. SS#1 staffrom CMA #4.  The ADM stated the the cameras for the was for one shift. SI whole day. She was thoroughly investigated action. The ADM stated in ADON] thought CMA from what she remet ADON] thought it was stated she argued where the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of rescaled in the staff member. So remain anonymous. | p.m., the Social Services[SS] sked to describe the to the grievance form dated ted she took the statement  ADON and herself looked at 07/19/20. She was asked if it he stated they looked at the staked if the incident was ted. The ADM stated, "No."  CMA #4 received disciplinary ated, "Yes." She was asked  ON and ADON had decided. Her opinion, they [DON and A #4 was lying. SS#1 stated, mbered, they [DON and as a fraudulent report. SS#1 was a fraudulent report. SS#1 was retaliation against the stated CMA #4 wanted to  p.m., CMA #3 was asked if porting allegations of abuse. If No." She stated if LPN #3 raid she'd come back at me."  Abuse/Neglect Policies | F 60                |  |         |                            |

| AND DI AN OF CORRECTION IDENTIFICATION NUMBER |  | 1 ' '  | PLE CONSTRUCTION  G | , ,   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|--|---------------------|---|----------------------------|----------------------------|--|
|   |  | 375488   | B. WING _           |   |                            | C<br>07/01/2021            |  |
| NAME OF P                                     | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706               | I                          | 0770172021                 |  |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 607   | substitute to investigate any substitute to investigate any substitute to the substi | resident property, lish policies and procedures ich allegations, and e training as required at  T is not met as evidenced mediate Jeopardy (IJ) inned to exist related to the velope and implement an ocedure that promoted an e allegations of abuse could r of retailiation, residents of abuse and neglect, | F 6                 | 07  |                            |                            |  |
|   | member was allowed.  The facility documer being physically abureported by staff. The   | not protected as the staff d to work.  Inted an incident of resident #5 sed by staff witnessed and the facility failed to protect the thorough investigation and   |                     |   |                            |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |                    |  |
|---|---|---|---------------------|---|--------------------|--|
|   |   | 375488  | B. WING             |   | C<br>07/01/2021    |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             | 1 07/01/2021       |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETION |  |
| F 607   | abuse.  Resident #8 made at on 06/28/21 and the continue to work over allegation was made.  Staff witnessed verbars an employee and reproted to the action of the investigation residents were not properpetrator remaining work while the investigation of the IJ signature.  At 11:04 a.m., the Office Health (OSDH) was existence of the IJ signature.  At 11:28 a.m., the Action of the IJ.  An acceptable, amenorated by the administration of AMENDED of THESE items will be 2021 [By 8:00 p.m.].  Misappropriation Inversidation of the IJ.  Misappropriation Inversidation of the IJ. | measures to prevent further  n allegation of rape by staff staff had been allowed to r six hours after the  al abuse to Resident #6, by borted it. The allegation was dministrator timely and a rn was not conducted. The rotected due to the g at work and continued to rigition was on going.  Alahoma State Department of notified and verified the function.  Iministrator (ADM) was  anded plan of removal was inistrator on 06/29/21 at 7:20 the following:  Removal for IJ's - ALL completed by June 30th, Abuse, Neglect, estigation POLICY was | F 60                |   |                    |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |   | ) COM               | E SURVEY<br>PLETED  |          |                            |
|--|---|---|---------------------|---|----------|----------------------------|
|  |   | 375488  | B. WING             |   | 1        | C<br>/ <b>01/2021</b>      |
| NAME OF P  | ROVIDER OR SUPPLIER   | J   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             | <u> </u> | 70172021                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 607  | 06/28/21 [staff name [CNA #6] and [LPN #06/30/21  An ADMINISTRATIVE the INCIDENT RESE and includes the Adradministrator, DON, Center Resident ser administrator or desi Director any allegatic scheduled monthly response an outside source or including screening, Investigating, protect on 06/30/21 with advalways protect our reresponse team will respond to allegation investigation has been information related to administrative staff vable to state accurate abuse and neglect.  The immediate jeopa of 06/30/21 at 5:10 pplan of removal and had been implement remained at a level of Based on observation and staff interviews, | e to further consideration on e deleted] was terminated.  disal will be terminated on  E team was formed called PONSE TEAM on June 29th, ministrator, Assistant ADON, and HealthCare vices Director. The gnee will report to Board of on of abuse at regularly neetings at a minimum. The team will be in-serviced by a all aspects of ABUSE - preventing, identifying, ting, and reporting/response vanced traing on Abuse. To esidents, the INCIDENT neet to collaborate and its to ensure all thorough | F 60                | 07  |          |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|--|--|---|-------------------------------|----------------------------|
|   |   | 375488  | B. WING                                |  |   |                               | 01/ <b>2021</b>            |
| NAME OF PI  | ROVIDER OR SUPPLIER   |   |  | 3  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>101 SOUTH OAKWOOD ROAD<br>ENID, OK 73706 | 1 077                         | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |  | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) |   |                               | (X5)<br>COMPLETION<br>DATE |
| F 607   | actions for six [#1, 5, sampled residents retailed facility.  Findings:  An employee handboth documented, "The preventabuse byFadverse action when report any genuine or regardingabuseThe retailation, in any formaking a report, comfaithAbuse & Negle ABUSE OR NEGLECT MUST BE REPORTE IMMEDIATELYFAIL OR NEGLECT, EVEN NEGLECT, LEAVES THE SITUATIONBut Commons will not, in or harassing behavior violation of this policy | egations timely, gh investigations, dents, ective measures and e held accountable for their 6, 7, 8 and #9] of six viewed for abuse.  95 residents resided in the  ok, dated 03/2020, Company actively works to Protecting employeesfrom they do the right thing and oncern the Company strictly prohibits n, against any individual plaint, or inquiry in good ct PolicyNO FORM OF ET IS TOLERATED AND | F                                      | 607  |   |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '              | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|--------------------|--|---|-------------------------------|--|
|   |   | 375488  | B. WING _          |  |   | C<br><b>07/01/2021</b>        |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | 1   |                    | STREET ADDRESS, CITY, STATE, 2           | ZIP CODE  | 00202.                        |  |
| THE COM   | MONS  |   |                    | 301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706 |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFI<br>TAG | X (EACH CORRECTIVE<br>CROSS-REFERENCED   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               |  |
| F 607   | voice at in individual Cell PhonesCell ph time onlyCode of C ProceduresViolatic rulesmay result in up to and including cabuse of the residen or mental abuse by MediaEmployees r confidentialabout not disparage any per confidential | umiliatingShouting, raising in publicTelephone Calls & none use is limited to break conductDisciplinary ons of any of these corrective action being taken, lischargePhysical or mental its or failure to report physical othersSocial must not postclientsEmployees should ersonbased ondisability"  ed 12/08/2020, documented, nentsallegations shall be y to the administrator, DON in accordance with State involve abusemust be ursThese allegations must igated and must prevent se while the investigation is in the action must be taken e appropriate licensing It [sic] the policy of The resident will be free from facility staff will be in-serviced int, and at least annually | F                  | 607                                      |   |                               |  |

| AND BLAN OF CORRECTION INDESTRUCTION NUMBERS |   | ` ′   | PLE CONSTRUCTION  G | , ,  | (X3) DATE SURVEY COMPLETED |                            |
|--|---|---|---------------------|--|----------------------------|----------------------------|
|  |   | 375488  | B. WING             |  |                            | C<br>07/01/2021            |
| NAME OF P                                    | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | I                          | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |
| F 607  | assessment immedin detailTake a staresident2ndIsolaImmediately notify"  1. Resident #9 had chronic pain and os: A resident assessm documented the resmoderately impaired. A care plan, effectivResident is at risl muscle spasms and syndromeResident treated/relieved in a medications as press. Physician's orders, "hydrocodone 7.5 m 325 mg tablet (Nordevery 8 hours as new Tylenol 325 mg cap route every 6 hours.  Ultram 50 mg tablet route every 6 hours. A statement from Cl 12:35 a.m., docume multiple occasions, in the morning after [Resident #9] get up ask for a pain pill. In the statement for a statement for a pain pill. In the statement for a statement for a pain pill. In the statement for a pain pill the statement for a pain pill the statement for a pain pill t | pervisor should do a medical latelydocumenting any injury stement from the late the perpetrator3rd of the Administrator, then DON diagnoses which included teoarthritis.  ent, dated 01/14/2021, sident's cognition was d.  e date 01/07/21, documented, of for pain r/t [related to] of chronic pain twill have pain timely mannerAdminister | F 6                 | 07   |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` '   | IPLE CONSTRUCTION  IG | , ,   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|---|---|-----------------------|---|----------------------------|----------------------------|--|
|   |   | 375488  | B. WING _             |   | 0                          | C<br>7/01/2021             |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                 |                            | 770 172021                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 607   | request to the charge go to the resident to report back to me, the administer a pain melevel of the pain that location of th [sic] pain [LPN #3], will deny the name], pain meds statedoesn't need a pain is smoke a cigarette, he he can go outside to pain pill because he loon these occurances pain meds until some p.m. as reflected on the administration record administration record An OSDH incident for documented, "[Restabuse/Mistreatment. IncidentStaff report pain meds when resing Resident is cognitive called"  A statement from LPI 12:23 [did not documented, "Somet pills when it is not time is scheduled [every] offered Tylenol if Nor Safe surveys were controlled to receiving personal statement of the pills when it is not time is scheduled [every] offered Tylenol if Nor Safe surveys were controlled to receiving personal statement of the pills when it is not time is scheduled [every] offered Tylenol if Nor Safe surveys were controlled to receiving personal statement of the pills were controlled to receiving personal statement of the pills were controlled to receiving personal statement of the pills were controlled to receiving personal statement of the pills were controlled to receiving personal statement of the pills were controlled to receiving personal statement of the pills were controlled to | ol, as the CMA, I report the enurse, the charge nurse will evaluate the resident and e CMA, with guidance to d and instruct me with the was reported and the n. On many occurances, he resident, [Resident's ating 'He just got up, he bill' or 'He's going outside to be's not hurting bad enough if smoke' or 'He can't have a masn't eaten anything yet.' or, [Resident] won't receive etimes 10 a.m or as late a 2 the MAR [medication]"  Trm, dated 06/26/21, ident #9]Allegations ofDescription of ed Nurse not approving PRN dent asked for them. and needs no family  N #3, dated 06/27/21 at tent a.m. or p.m.], imes resident asks for pain he as he had it earlier. Med as [hours] prn. Resident is co can't be given yet"  Inducted with five residents. To the residents were not ain medications. The facility gation was unsubstantiated | F 6                   | 507   |                            |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|--------------------|---|---|--|-------------------------------|--|
|  |   | 375488  | B. WING _          |   |   | 1  | 01/ <b>2021</b>               |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |   |                    |   | DRESS, CITY, STATE, ZIP CODE  1 OAKWOOD ROAD  73706   | <u>,                                    </u> | 01/2021                       |  |
| (X4) ID<br>PREFIX<br>TAG                         | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE    |  |
| F 607  | assistant administrate conclusion of the investad administrator stated is spreadsheet of which versus the Norco. She had administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it withheld the medicatic conclusion the allega She stated she went him about it. She stanurse's biggest cheer.  At 1:19 p.m., the ADN There were no questirelated to staff withheld stated the executive of surveys and thought members respect you make decisions regard that.  On 06/29/21 at 6:35 pif he was in pain. He right side, leg and known as in pain. He right side, leg and known as in pain. He right side, leg and known as in pain. He right side, leg and known as asked if his Norce stated, "If I don't go was asked if his Norce stated it was once. How he gets it. He was in peter it. | p.m., the administrator and or were asked about the estigation. The assistant she had made an excel a nurse had given Tylenol ne stated the accused nurse medications as much as the as asked if there was times the resident had She stated she didn't think to had requested it. She was a documentation of when the and the CMA stated LPN #3 on, how did they come to the tion was unsubstantiated. | F                  | 607                                     |   |  |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | PLE CONSTRUCTION IG | , ,  | (X3) DATE SURVEY COMPLETED            |                            |  |
|---|--|--|---------------------|--|---------------------------------------|----------------------------|--|
|   |  | 375488   | B. WING _           |  |                                       | C<br>07/01/2021            |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | J  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706      | · · · · · · · · · · · · · · · · · · · | 0770172021                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                             | (X5)<br>COMPLETION<br>DATE |  |
| F 607   | allegations made reg<br>Norco. She stated, 'the time." She state<br>when he asks for so<br>have to follow." She<br>give the same respo<br>statement. She state<br>their pain as they state<br>would have her adminstead of the Norco.  The facility failed to a<br>abuse policy and pro-<br>accurate a thorough<br>allegations abuse. If<br>develope and impler<br>protecting residents.  2. Resident #7 was a<br>diagnoses which inconviety disorder.  A quarterly resident<br>documented the resi<br>impaired.  A state incident report<br>documented, "Incianted."  A state incident report<br>documented, "Incianted."  A state incident report<br>documented incident report<br>documented incident report<br>documented incident report<br>documented. "Incianted."  A state incident report<br>documented incident report<br>documented incident report<br>documented incident report<br>documented. "Incianted."  A state incident report<br>documented incident report<br>documented incident report<br>documented. "Incianted."  A state incident report of verbal a<br>from a staff member is not on the schedu<br>not be working until investigated. Investigated. | sing to tell.  3 was asked about the garding LPN #3 withholding 'Norco is what he asks for all d, "It's upsetting to me cause mething, I have protocol I stated that LPN #3 would nses CMA #3 had put in her ed she was taught to take ated it. She stated LPN #3 inister Tylenol or Ultram develope and implement and ocedure that allowed fo an investigation into the The facility further failed to ment an abuse policy for from abuse and negeclt.  admitted to the facility with luded convulsions and assessment, dated 02/18/21, dent's cognition was severely of the form, dated 02/23/21, dent TypeAllegations of | F 6                 | 07   |                                       |                            |  |

| ,                        |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |   | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|--|---|---|---|---|----------------------------|--|
|                          |  | 375488  | B. WING _                               |   |   | C<br><b>07/01/2021</b>     |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |   | STREET ADDRESS, CITY, STATE 301 SOUTH OAKWOOD ROAD ENID, OK 73706 |   | 07/01/2021                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | ( (EACH CORRECTIV<br>CROSS-REFERENCE                              | AN OF CORRECTION<br>/E ACTION SHOULD BI<br>D TO THE APPROPRIA<br>ICIENCY) | DATE                       |  |
| F 607                    | implemented to preve attached for investigated resident. She was standard ways to recognize but a many standard remainstrator until the statement of the statem | and corrective measures ent recurrenceSee ation: Nurse yelled at uspended and counseled on urnout. Also gave her enformation"  Itse was not reported to the enext day after it occurred.  The appropriate agencies such the Department of Health  The day sitting in the North Hall the hother resident]s room. At [resident #7] wheeled hair up closer to the nurse's sted himself in his wheelchair | F 6                                     | 507   |   |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |     |                                       | (X3) DATE SURVEY<br>COMPLETED |         |
|---|--|--|--|-----|---------------------------------------|-------------------------------|---------|
|   |  | 375488   | B. WING  |     |                                       |                               | 04/0004 |
| NAME OF D   | ROVIDER OR SUPPLIER  | 373400   | B: Wille   |     | CTREET ADDRESS OFF STATE ZID CODE     | 07/                           | 01/2021 |
| NAIVIE OF PI  | ROVIDER OR SUPPLIER  |  |  |     | STREET ADDRESS, CITY, STATE, ZIP CODE |                               |         |
| THE COM   | MONS   |  |  | l   | 301 SOUTH OAKWOOD ROAD                |                               |         |
|   |  |  |  |     | ENID, OK 73706                        |                               |         |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY) |     |                                       | (X5)<br>COMPLETION<br>DATE    |         |
| F 607   | #4] came into work I v sitting at nurses static came strolling up to the nurses station [LPN # around and go back I said I dont care Im not and he said he wanter screamed at him and your [sic] not sitting up deal with your Ass. so Corner til [LPN #3] left of the evening"  A written statement by documented, "The ott getting something what [resident #7]. And [Resident #7] started #3] got louder and tollisten to it. Go to you Im sick of him acting I have to getting something what [administrator (administrator (administrator (administrator (administrator (administrator yelling Monday February 22r [approximately] [2:00 the man but suppose [admin] via the camer told I told male reside hall or go to his room to sit in the area by wit congests the hallwat towards the resident | nday February 22nd I [CMA was on North Hall. I was on [resident #7] the resident ne Common Area by the said he has rights She of gonna [sic] deal with you do to sit up here She said "I dont give a dam [sic] p here Im not gonna [sic] p here Im said in the fit he was very upset the rest of the was in the office en I heard [LPN #3] yelling telling him to go to his room. yelling back at her and [LPN do him she wasn't going to room. [LPN #3] then said like this"  The yell of the was very upset the rest of the was an allegation [at] a male on North Hall on and [at] approx p.m.]Not only did I yell [at] dly I cussed [at] him also per ras. No AudioWas also ont to go away, go down the the lad asked residents not ound care Nurse's office as byMay of raised my voice | F  | 601 | 7                                     |                               |         |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′  | PLE CONSTRUCTION    | · /  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   |  | A. BOILDING         |  | l ,                           | c                          |
|   |   | 375488   | B. WING             |  | 1                             | 01/2021                    |
| NAME OF PE  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 011                         | 01/2021                    |
|   |   |  |                     | 301 SOUTH OAKWOOD ROAD   |                               |                            |
| THE COM   | MONS  |  |                     | ENID, OK 73706   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE |
| F 607   | Continued From page   | 45   | F 60                | )7   |                               |                            |
| 1 507   | "Who is/are the reported victim[resident #7]Who is/are the reported perpetrator[LPN #3]Who witnessed the incident[CMA #3], [CNA #3], [CMA #4]What happenedResidentwas in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the deskWhat is the history of the resident(s)? Was the incident foreseeableThe resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeableWhat does the victim want to happen[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulderWhen did the incident happenAround 2pm on Feb [February] 22ndWhen was facility supervisory/management staff first contacted about the incidentOn Feb 23rd" |  |                     |  |                               |                            |
|   | Name: [LPN #3]Did or Criminal Behavior abuseDescription of suspended pending the returned to work on 0 disciplinary action write a resident and for concontrary to recognized employment at the fact A time sheet for pay proceed to 102/27/21, documented p.m. on 02/22/21. LP 4 hours and 48 minutes  | f InvestigationLPN was<br>ne investigation and<br>2/26/2021. She received<br>te up for raising her voice at<br>ducting herself in a manner |                     |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                      | I ' '               | PLE CONSTRUCTION  G  | , ,      | (X3) DATE SURVEY COMPLETED |  |  |
|---|--|---|---------------------|--|----------|----------------------------|--|--|
|   |  | 375488  | B. WING _           |  |          | C<br>07/01/2021            |  |  |
|   | NAME OF PROVIDER OR SUPPLIER  THE COMMONS  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706        | I        | 0770172021                 |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |  |  |
| F 607   | the administrator and not completed.  On 06/23/21 at 2:24 to describe the incide 02/22/21 with reside resident is hard of he didn't yell. She state took statements from and discussed the in wife. She was asked 02/22/21. She state asked when the incide stated she was notifit was asked what the was. She stated it will dit. She stated it will dit. She stated she wite up. She was a tolerance for abuse, hand book is wrong, done to protect and to other residents. Sanything else other the was asked who the sabuse to. She stated asked when the staff did they report timely asked if the staff who in serviced about report. On 06/24/21 at 1:09 verbal abuse happer p.m. She stated "Ye continued to work af |   | F 6                 | 07   |          |                            |  |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |          | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---|---|----------|-------------------------------|--|
|                          |  | 375488   | B. WING                                 |   |          | C<br>07/01/2021               |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706                       |          | 07/01/2021                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 607                    | stated," They couldr about it." She was a report the abuse improtected. She stated. The ADM was asked after the incident. So The staff members worked with the victi approximately four hot immediately reposed with the victi approximately four hot facility did not poplace to prevent aburesult, one of the with allegation of verbally. The facility substant terminated CMA #4 employed by the facility failed to abuse policy and productions abuse. The facility failed to abuse policy and productions abuse. In develope and impleind protecting residents.  3. Resident #5 was diagnoses which incomented the residuly decision making. An initial incident reported the substantial incident repor | the resident protected. She I't be, because we didn't know asked, since the staff failed to mediately, were the residents ed, "No."  If if the resident was assessed the stated, "No."  Who witnessed the abuse did out it. As a result, LPN #3 m and other residents for mours and 48 minutes.  If any corrective measures in use from reoccurring. As a messes [CMA #4] had an and abusing a different resident. It is ated allegation and while LPN #3 continued to be sility.  If a continued to be an investigation into the content an abuse policy for from abuse.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia.  If a continued to the facility with luded dementia. | F 6                                     | 07  |          |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ` '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|---|---|-------------------------------|----------------------------|--|
|  |   | 375488   | B. WING _                               |   |                               | C<br>07/01/2021            |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706             |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFI)<br>TAG                     | PROVIDER'S PLAN OF CO<br>X (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |  |
| F 607  | A written statement fr 06/07/21, documente #2] asked me if I coulyes just give me a se middle of taking care I walked into [residen ahold [sic] of his Righon him while she was bare skin I yelled at way [and] she was lik dropped him back on his arm to get him up would take care of his breakfast [and] told th just happened. When #2] she told her to sta [resident #5]. When [10:00 a.m.] I asked i [and] I told [DON] wh me she was not awar asked me to write our A written statement fr documented, "[CMA ayelled at [CNA #2] be me to help get him [resom where she was at her states she saw at his left leg so I told finish him, I went to [thappened she said I | Description of n allegation of abuse staff member. Staff pending investigation"  om CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had at arm yanking [and] pulling a slapping at his left leg,-on ther to stop doing him that the what [and] just kind of the bed, she went to pull on I told her to just leave that I m. I brought him out for the Charge Nursewhat had the [LPN #2] talked to [CNA ay away from direct care of I seen [sic] D.O.Naround f [LPN #2] had talk to her at had happened She told the but now she is [and] | F                                       | 507   |                               |                            |  |

| ` '                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |          | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---|---|----------|-------------------------------|--|
|                          |   | 375488   | B. WING _                               |   |          | C<br>07/01/2021               |  |
|                          | NAME OF PROVIDER OR SUPPLIER  THE COMMONS   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                       | •        |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 607                    | documented, "[residesided [sic] to get he then uncovered him was getting him dresh his pull-up on the [side after that I took his heady to put his arm went to put his head me. got his head in the shirt down. The tried to son leg to Push Leg in have my other hand him sit up. Then hold stand him to finish gower was fighting me. I we [sic] him down to rest [CMA #2] came in the hold him up. Then to the [sic] she would gown. [LPN #2] told until told other wise  An investigative sum "Who isthe report #2]What happened yanking on Resident legWhat was done from further harm Saround the resident nurse on the hall and sent home pending in DONWhat is the hit the incident foreseed. | from CNA #2, dated 06/07/21, ident #5] was awake. So him up. got his clothes ready started talking to him while seed. I started by putting [sic] c] then i put his pants on. ospital gown off. got his shirt in. then put the arm in as I his shirt, I told him not to Bite he whole [sic] [and] pull his sit him up By Putting my arm a sitting position while i around upper back to help ered [sic] at [CMA #2] to help etting dressed. Because he has patting hisleg to clam sure [sic] it was ok. then eir [sic] saw i was trying to had me Let him lay Back down et him. then said was he room and went the Break eask me if i hit him I told him to try come [sic] him me not go around him again"  Imarry, undated, documented, the diction[resident did perpetrator[CNA dAllegation that CNA was as arm and slapping his to protect the resident(s) staff member was told not go until further notice by the did then was suspended and | F 6                                     | 07  |          |                               |  |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|--|-----|--|-------------------------------|----------------------------|
|                          |  | 375488   | B. WING                                | -   |  | C<br>07/01/2021               |                            |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  | -                                      | 3   | STREET ADDRESS, CITY, STATE, ZIP CODE SO1 SOUTH OAKWOOD ROAD ENID, OK 73706                                  | 1 077                         | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 607                    | supervisory/managen about the incident[1  A final state report, da "A skin sweep was by two nurses with not Accused perpetrator to 06/07/2021 pending a 06/08/2021 she was of the Administrator. Shor what could be consulso completed a Reli Understanding Deme perpetrator was allow 06/08/2021"  CNA #2's time sheet, documented she world a.m. to 10:04 a.m., ar a.m. and on 06/08/21 and from 1:57 p.m. to the facility had documented to investigation by intervand residents.  On 06/24/21 at 12:48 to describe her invest she would complete a and suspend staff, tall staff on the hall that the complete safe survey the section of the hall | the incident :30 a.m.]When was facility nent staff first contacted 0:00 a.m.]"  ated 06/08/21, documented, completed on the resident o injuries notedThe was suspended on an investigation. On counseled by the DON and he received verbal education sidered to be abuse. She has Training entitled intia. The accused red to return to work on  dated 06/06/21 to 06/19/21, ked on 06/07/21 from 6:30 and from 10:36 a.m. to 11:37 from 8:27 a.m. to 1:27 p.m., o 2:32 p.m.  mented the allegation was a through there was a complete a thorough viewing other staff members  p.m., the DON was asked higation process. She stated an incident report, remove ke statements from other he incident occurred and s on cognitive residents on the incident occurred. She reked the same hall. She | F                                      | 607 |  |                               |                            |

| ` '                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |           | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|---|--|---|--|-----------|----------------------------|--|
|                          |   | 375488   | B. WING                                 |  |           | C                          |  |
| NAME OF PI               | ROVIDER OR SUPPLIER   | 070400   |   | STREET ADDRESS, CITY, STATE, ZIP CODI 301 SOUTH OAKWOOD ROAD ENID, OK 73706          | <b>I</b>  | 07/01/2021                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 607                    | on other halls. She so ther staff but not oth asked when the investigation stated on 06/07/21 at when the investigation stated late on 06/07/21 thorough investigation stated, "I feel it was the resident was assed delayed injury. She stated late on 06/07/21. She stated lunch and when she is suspended and sent she worked on 06/08, here at 8:30 a.m. to in Relias training then rewas asked what discinceived. She stated about dementia, she and two and a half how was asked what correplace to prevent furth residents. She stated about dementia, she and two and a half how as asked what correplace to prevent furth residents. She stated about dementia, she and two and a half how as asked what correplace to prevent furth residents. She stated the DON stated she happened because C and she called the CI acknowledged staff did the incident in a time!  LPN #2 did not report immediately and as a work with other reside and a half to two and investigation was not | ang other staff and residents tated she has interviewed er residents. She was stigation was started. She in 10:00 a.m. She was asked in was completed. She in was conducted. She in was asked if it is essed after incident for stated, "No."  If CNA #2 had worked on it is he left at 10:04 a.m. for returned, she was shome. She was asked when was in was asked when was asked if each was asked when was asked if an was asked if an asked when was asked if an asked with a state of the was asked if an an | F6                                      | 507  |           |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | , ,  | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |                    |  |  |
|---|--|--|---------------------|---|--------------------|--|--|
|   |  | 375488   | B. WING             |   | C<br>07/01/2021    |  |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                           | •                  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE COMPLETION |  |  |
| F 607   | abuse policy and proaccurate a thorough allegations abuse. The develope and implement of the vacuum (vac) and passure ulcer to the vacuum (vac) an | develope and implement and ocedure that allowed fo an investigation into the The facility further failed to ment an abuse policy for from abuse.  diagnoses which included sacrum requiring a wound ain.  #2, dated 06/27/21, rked from 5:33 p.m. to 5:39  A #5, dated 06/27/21, rked from 10:01 p.m. to 5:39  ed 06/28/21 at 4:23 a.m., than [sic] began saying that a females every 30 to go in her room by so reported to administration  a.m., two police officers were be front door to the facility. They stated they had received had been sexually abused. They had received the pout five minutes ago."  ministrator stated, "I need to me stated, "We have a crazy has raped and I didn't send | F 60                |   |                    |  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY COMPLETED |                            |
|---|--|---|---------------------|--|----------------------------|----------------------------|
|   |  | 375488  | B. WING             |  |                            | C                          |
| NAME OF PI  | ROVIDER OR SUPPLIER  | 0.0400  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                        |                            | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 607   | Continued From page  | <del>=</del> 53   | F6                  | 07   |                            |                            |
|   | documented, "Final of Abuse/Mistreatmer IncidentResident median being raped by 50 per was also saying were when staff CMA gave [signs/symptoms] of pay and final reports, of the investigation | akes allegation that she was ople every 30 minutes. She were trying to poison her her ultramNo S/S obysical rape notedFor 5 please include a summary See attached  ate and time of report at 5:10 p.m., documented, orted perpetrator(s)A mWhat on of Rape and bed e to protect the resident(s) taff was to always go in not was done upon discovery ed AdministratorWhat is physical done at 5PM facility ent staff first contacted 1:47 PM [06/27/21]"  #2 documented, p.m. to 11:15 p.m.] Resident ere was bed bugs in her bed. If by 2 staff and found no an [sic] began saying that has been yelling these that the rapest [sic] is a so of them every 5 minutes. Scribe them Staff has been the 2 people and then after stration we have been going |                     |  |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ` ′   | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED  |         |                            |  |
|---|--|---|---------------------|---|---------|----------------------------|--|
|   |  | 375488  | B. WING _           |   | 07/0    | 1/2021                     |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                           | ·       |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 607   | Continued From pag   |   | F 60                | 07  |         |                            |  |
|   | 12:32 p.m., document #8] started yellingS yelling rape. She sare everyone has been in been raped every 30.  A statement, dated 0 documented, "Residabused and raped resident #8's room in Rape multiple times coming"  On 06/28/21 at 6:27 had received a text in nurse last night at 17 resident's wound varwas observed to be from the charge nurse when the nurse wen resident alleged rapet the nurse had inform to go in there alone. told the nurse to go aget a description of variety and 50. The charge nurse to "looks like us." | IA #5, dated 06/28/21 at Inted, "At 11:14 pm [Resident Shortly after she started id she was raped and that raped. She said that she has iminutes by 50 people"  In 6/28/21, from CNA #7, ent stated she was being epeatedly"  In 6/28/21, from CMA #5 In 28-2021, resident in RM number] has been yelling and saying the police are  In a.m., the ADM stated she message from the charge in the charge in the charge in the charge in the chard alarmed. The ADM reading the text messages as we spoke. She stated in to check the alarm, the end and in the chart in the person looked like. The administrator stated she cask when it happened and what the person looked like. DM the resident reported a people every 30 minutes. In the many staff had worked in the ADM that the rapist in the chart |                     |   |         |                            |  |
|   | with the resident last<br>She stated she had   | night. She stated, "Two." nstructed the nurse to inform cian and to assess the  |                     |   |         |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING  |                    | IPLE CONSTR<br>NG   | UCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|--------------------|---|--|-------------------------------|----------------------------|
|  |   | 375488  | B. WING _          |   |  | 1                             | 01/ <b>2021</b>            |
| NAME OF PI                                       | ROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706 |  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                         | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 607  | assessed. The adminurse, "You can't rap close to." She was a that had been workin stated it was a CNA at the ADM was asked residents once she wallegation of rape. Swith two, always two facility policy was for was an allegation of find the policy." She reading it. She state them, suspend." She two staff had been suat the time." She stated, "I don't keen she was asked what she stated, "I don't keen she was asked if her employees for allegated followed. She stated.  On 06/29/21 at 11:30 regarding resident #8 reviewed with the AD her report on the stated. | the resident refused to be nistrator stated she told the e someone you can't get asked who the two staff were g with the resident. She and an RN.  how she protected the was made aware of the he stated, "I told her to go in "." She was asked what the protecting residents if there abuse. She stated, "Let me located the policy and began d, "Immediately remove e was asked if either of the uspended. She stated, "Not ted, "I came and did it later." time she suspended them. now, I was with the police." policy for suspending tions of abuse had been I, "No." | F                  | 507   | DEFICIENCY)  |                               |                            |
|  | 06/28/21, where she texted her that the re perpetrators as "look investigative report dunable to give a desc"Yes", referring to the information. She was concerned about the  | reported the charge nurse sident described the s like us" and that the ocumented the resident was cription. The ADM stated, e discrepancies in  |                    |   |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '  | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |                   |  |  |
|---|---|--|---------------------|---|-------------------|--|--|
|   |   | 375488   | B. WING             |   | 07/01/2021        |  |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | 1  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             |                   |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETIC |  |  |
| F 607   | reported to her the d "looks like us" and the resident was unable. There was no respons The two employees facility all night after resident identifying the who raped her.  The facility failed to a abuse policy and pro- accurate a thorough allegations abuse. To develope and impler protecting residents  5. Resident #6 had of Huntington's disease A resident assessmed documented the resi A time record, dated #1 worked from 5:42  A nurse's note, dated documented, "Resid back"  An initial OSDH incid documented, "Alled MistreatmentDescription incidentAdministrat director that activity a statement, that she of F******* Christ, [Resid | rday that she stated the nurse escription the resident stated he report documented the to describe the perpetrator. In the given.  I remained working at the state allegation of rape and the he RN and CNA as the ones develope and implement and ocedure that allowed fo an investigation into the The facility further failed to ment an abuse policy for from abuse.  I diagnoses which included esc.  I dated 02/15/21, deent's cognition was intact.  03/21/21, documented LPN ea.m. to 3:21 p.m.  I d 03/21/21 at 1:44 p.m., ent observed on floor lying on dent report, dated 03/21/21, gations of Abuse | F 60                |   |                   |  |  |

| STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING |  | , ,  | (X3) DATE SURVEY COMPLETED |   |             |                            |  |
|--|--|--|----------------------------|---|-------------|----------------------------|--|
|  |  | 375488   | B. WING                    |   |             | C<br><b>07/01/2021</b>     |  |
| NAME OF F  | PROVIDER OR SUPPLIER   |  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706               | E, ZIP CODE |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE    | (X5)<br>COMPLETION<br>DATE |  |
| F 607  | The nurse is suspendomplete" A facsir documented the repolic of the resident.  There was no documed inical record of the resident.  The facility did not reto the Oklahoma Stawithin the required two A time record for LPI worked on 03/23/21.  A final OSDH report, at 6:38 p.m., documed day and final reports of the investigation investigation attached.  Safe surveys were con 03/23/21. The foliasked:  1. Do you feel like willight, you get everyth 2. Have you heard stanguage?  3. Has staff ever yell 4. If you feel like you know who to talk to? No negative answers.  LPN #1 reamained were verbal abuse had be investigation. | ded until investigation is nile (fax) cover sheet, ort was sent to the OSDH on a sent to the osport the allegation of abuse to Department of Health who hours.  N #1 documented she from 5:42 a.m. to 2:34 p.m.  faxed to OSDH on 03/23/21 ented the followingFor 5 please include a summary face Sheet attached, d"  conducted with three residents lowing questions were then you turn on your call ing you need taken care of? The staff using inappropriate the dor spoken harsh to you? In needs aren't met, do you | F 6                        |   |             |                            |  |

|   | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  |   | , ,      | COMPLETED                  |  |
|---|--|---|--|---|----------|----------------------------|--|
|   |  | 375488  | B. WING  |   |          | C<br>07/01/2021            |  |
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS |  |   | STREET ADDRESS, CITY, STATE, ZIP COD  301 SOUTH OAKWOOD ROAD  ENID, OK 73706 |   | ·        |                            |  |
| (X4) ID<br>PREFIX<br>TAG                  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 607                                     | or other staff with the administrator docum the staff member may others. She documenter reported hearing the member who had may administrator docum incident did not occur. On 06/24/21 at 1:35 when LPN #1 worked she worked til 3:21 pdid the LPN receive. She was asked when completed. She staff completed, but the did stated there was corrand LPN #1. She was worked during the in stated, "Yes." She will place to prevent reor residents. She states She was asked, how protected if the LPN investigation. She stre-interviewed and he allegation could asked if was reported not notified until the On 06/25/21 at 3:09 asked if she recalled She stated she did. Cursed at the resider that he had fallen. So "Jesus F*** Christ, [Issus F | per, the perpetrator (LPN #1) e investigation. The ented that she had spoken to aking the allegation and three ented she spoke with resident d the only person who comments was the staff ade the allegation. The ented her conclusion was the ented her conclusion was the enter.  p.m., the DON was asked d on 03/21/21. She stated e.m. What disciplinary action The DON stated, "None." In the investigation had been ed the investigation was ocumentation was not. She entitic between the activity aide eas asked if LPN #1 had exestigation. The DON eas asked what was put in courrence and to protect the ed there were no changes. It residents had been worked during the tated the complainant was ad a discussion about how not have occurred. She was d timely. She stated she was | F 6  | 07  |          |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING |  |  | (X3) DATE SURVEY COMPLETED |     |   |       |                            |
|---|--|--|----------------------------|-----|---|-------|----------------------------|
|   |  | 375488   | B. WING _                  |     |   |       | C<br><b>01/2021</b>        |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                            | 301 | EET ADDRESS, CITY, STATE, ZIP CODE SOUTH OAKWOOD ROAD D, OK 73706   | 1 077 | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | <   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 607   | and that her supervis administrator.  The facility failed to dabuse policy and proallegations timely to tapprorpaite agencies during an investigation investigate an allegated.  Resident #1 was a diagnoses which included a quarterly resident a documented the residing and investigate an allegated.  A quarterly resident and documented the residing and investigate an allegated.  A state incident report documented, "Resimpaired.  A state incident report documented, "Resimpaired.  A notification of nursed 06/12/21, documented employee terminated 06/12/2021ALLEG/ABUSEOn June 12 11:00 am a incident with member in which a Rinvolved. CNA #1 resident expersonal SnapChat is does your resident expersonal SnapChat is does your resident expersonal SnapChat is does your resident expersonal face emojical was terminated for minimal and incident in the captilla and incident expersonal snapChat is does your resident expersonal snapChat is does your | to her supervisor that day or was going to call the evelope and implement an cedure for reporting he administrator and that protected residents n, and thoroughly ion of abuse.  dmitted to the facility with uded Parkinson's disease.  ssessment, dated 06/12/21, dent's cognition was severely to form, dated 06/12/21, dentInvolved[resident Allegations of  e aide report, dated dd, "CNA #1wasYestermination date ATIONS/FACTS OF to 2021 at approximately was reported by a staff esident [resident #1] was corded [resident #1] tying her posted the video on her tory with the caption "But wer tie your shoes for no | F                          | 607 |   |       |                            |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING   |   |                     | (X3) DATE SURVEY<br>COMPLETED   |          |                            |  |
|--------------------------|--|---|---------------------|---|----------|----------------------------|--|
|                          |  | 375488  | B. WING _           |   |          | C<br>07/01/2021            |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                 | •        |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 607                    | when were the staff phone use and social inserviced when the She was asked what media restrictions waything about reside pictures. She stated cell phones in break phone in resident arthe staff were inserved She stated they pland July. She stated they had to wait for they weren't.  On 06/24/21 at 2:00 what staff were interinvestigation. She is they did not interview working that same is staff members were thorough investigation. The facility failed to abuse policy and protected from furthey did not initiate at the facility failed to abuse policy and protected from investigation.  7. A grievance conduction of the Company of the | a.m., the DON was asked inserviced related to cell al media. She stated they are y are hired during orientation. It the cell phone and social ere. She stated not to post lents, the facility and no distaff were only to have their room and not to have a cell eas. The DON was asked if iced related to the incident and on inservicing staff in ey were going to in June but their board's approval of the ewas asked if any corrective in place to protect the er occurrence. She stated eviewed as part as their stated CMA #1. She stated wother staff who were hift. She was asked if other not interviewed, was a on completed. She stated, as asked how residents were er occurrence. She stated any new interventions. | F 6                 | 07  |          |                            |  |

| F DEFICIENCIES<br>CORRECTION  |  |  |  | (X3) DATE SURVEY<br>COMPLETED   |  |
|---|--|--|--|---|--|
|   | 375488   | B. WING  |  |   | C<br><b>07/01/2021</b>   |
| ROVIDER OR SUPPLIER   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706  | ·   | 07/01/2021   |
| (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTION S  | SHOULD BE   | (X5)<br>COMPLETION<br>DATE   |
| door after she went couldn't open it. She the Med [medication yanked it around [ar When [CMA #4] said [and] retaliated agai Staff Assigned to InvestigateADON] 2-10 shift for 7/19/20 to confirm the above nurse and she state her and when [resid they put a mask on goResolution[CM discuss her allegation didn't back those allemployee warning for misrepresentation 2 manner contrary to morality [and] decer concern form]When refused to do anythin F words. Would thromake [CMA #4] pick every weekend she incident happened of anonymouswants  An employee warning documented, "EM event07/24/2020 TDishonesty [and] | in [and] hold the door so she e eventually came out again, n] aide grabbed her walker, nd] said "I'm tired of this shit. d anything, she was bullied nst InvestigationWatched the o on camera and saw nothing e complain. I talked to the d no issues were reported to ent] comes out of her room, her and let her MA#4] was called in to ons. Was informed the video egations up. She received an or 1) dishonesty, ) conducting one self in a recognized standards of ncy[On the back of the [CMA #4] told the nurse, she ng [and] just said a bunch of ow things off the desk [and] a them upThis happened has workedThis specific on 7/19/20Wants to remain to be notified of resolutions"  ng notice, dated 07/27/20, PLOYEE [CMA#4]Date of .PROBLEM/EVENT/INCIDEN misrepresentation about  | F 60   | 7  |   |  |
|   | CORRECTION  COVIDER OR SUPPLIER  MONS  SUMMARY S (EACH DEFICIEN REGULATORY OF CONTINUED FROM PROBLEM P | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 61 door after she went in [and] hold the door so she couldn't open it. She eventually came out again, the Med [medication] aide grabbed her walker, yanked it around [and] said "I'm tired of this shit. When [CMA #4] said anything, she was bullied [and] retaliated against  Staff Assigned to Investigation Watched the 2-10 shift for 7/19/20 on camera and saw nothing to confirm the above complain. I talked to the nurse and she stated no issues were reported to her and when [resident] comes out of her room, they put a mask on her and let her goResolution [CMA#4] was called in to discuss her allegations. Was informed the video didn't back those allegations up. She received an employee warning for 1) dishonesty, misrepresentation 2) conducting one self in a manner contrary to recognized standards of morality [and] decency [On the back of the concern form]When [CMA #4] told the nurse, she refused to do anything [and] just said a bunch of F words. Would throw things off the desk [and] make [CMA #4] pick them up This happened every weekend she has workedThis specific incident happened on 7/19/20 Wants to remain anonymouswants to be notified of resolutions"  An employee warning notice, dated 07/27/20, documented, "EMPLOYEE [CMA#4]Date of event07/24/2020PROBLEM/EVENT/INCIDEN TDishonesty [and] misrepresentation about | A BUILDING  375488  B. WING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 61  door after she went in [and] hold the door so she couldn't open it. She eventually came out again, the Med [medication] aide grabbed her walker, yanked it around [and] said "I'm tired of this shit. When [CMA #4] said anything, she was bullied [and] retaliated against  Staff Assigned to Investigate ADON]InvestigationWatched the 2-10 shift for 7/19/20 on camera and saw nothing to confirm the above complain. I talked to the nurse and she stated no issues were reported to her and when [resident] comes out of her room, they put a mask on her and let her goResolution[CMA#4] was called in to discuss her allegations. Was informed the video didn't back those allegations up. She received an employee warning for 1) dishonesty, misrepresentation 2) conducting one self in a manner contrary to recognized standards of morality [and] decency[On the back of the concern form]When [CMA #4] told the nurse, she refused to do anything [and] just said a bunch of F words. 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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |  | (X3) DATE SURVEY COMPLETED |   |                                |                        |
|---|--|--|----------------------------|---|--------------------------------|------------------------|
|   |  | 375488   | B. WING _                  |   |                                | C<br><b>07/01/2021</b> |
| NAME OF P   | ROVIDER OR SUPPLIER  | 1  |                            | STREET ADDRESS, CITY, STATE, ZIP CO<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706 | ODE                            | 0770172021             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC' | ION SHOULD BE<br>HE APPROPRIAT |                        |
| F 607   | against her co-worked On 06/23/21 at 8:30 staff reported suspect they reported it to the their chain of comma months ago, a reside abuse to her and and DON was busy testimeeting so they wer She stated they were chain of command, reported to if the DO stated they can alway phone.  On 06/24/21 at 11:10 she witnessed abuse month or two ago and She was asked when She stated staff typic of command but the abuse was her chain to state the incident She was asked if she stated she was hold it against her.  On 06/25/21 at 9:50 she had ever felt like incidents of allegation "Yeah." She stated, done." She stated, be more in trouble for At 3:09 p.m., the act had ever felt like she at the she was a she chain to state the incidents of allegation "Yeah." She stated, the more in trouble for the dever felt like she at the she at t | a.m., LPN #3 was asked who cted abuse to. She stated a DON because that was and. She stated, about three ent had reported verbal other nurse. She stated the ng staff, the ADM was in a at to the admin's assistant. A to the admin's assistant. A to the admin's assistant. A to the admin's assistant at to the admin's assistant. A to the admin's assistant at to the admin's assistant. A to the admin's assistant at to the admin's assistant. A to the admin's assistant at to the admin's assistant at to the admin's assistant. A to the admin's assistant at the told they had to go to their she was asked who they in a name and who did she report to a to the ADM. In and who did she report to a to the and who did she report to a to the and who had done the and for command. She went on was "traumatizing to me." A was afraid to report abuse. Worried that someone would a a.m., LPN #1 was asked if a she could not report as of abuse. She stated, "Sometimes things don't get the twe feel like people should | F6                         |   |                                |                        |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIF   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY COMPLETED |                            |
|--|--|---|---------------------|--|----------------------------|----------------------------|
|  |  | 375488  | B. WING             |  |                            | C<br><b>7/01/2021</b>      |
| NAME OF PR   | OVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | <u> </u>                   | 770 17202 1                |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |
|  | blew me off."  On 06/28/21 at 3:20 #1 and ADM were a investigation related 07/24/20. SS#1 staffrom CMA #4.  The ADM stated the the cameras for the was for one shift. S whole day. She was thoroughly investigated the cameras for the ADM stated in Information and the ADM stated in Information and the ADON] thought CM from what she reme ADON] thought it wistated she argued where the staff member. So remain anonymous.  On 06/29/21 at 7:02 she was fearful of respectively failed to The facility failed to | reported to her [ADM], she reported to describe the reported | F 60                |  |                            |                            |

| AND PLAN OF              | DF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ` ′   | ) MULTIPLE CONSTRUCTION BUILDING   |                | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|--|---|---|--|----------------|----------------------------|--|
|                          |  | 375488  | B. WING   |  | <sub>0</sub> . | C<br>7/ <b>01/2021</b>     |  |
| NAME OF PE               | ROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP CO<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706 |  | ·              |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE       | (X5)<br>COMPLETION<br>DATE |  |
| F 607                    |  | ge 64<br>acility policy and procedure<br>ped and implemented for  | F 60  | 77   |                |                            |  |
| F 609<br>SS=K            | Surveyor: Green, Sa<br>Reporting of Alleged<br>CFR(s): 483.12(c)(1<br>§483.12(c) In respo  | d Violations  | F 60  | 9  |                |                            |  |
|                          | §483.12(c)(1) Ensurinvolving abuse, negmistreatment, include source and misapporare reported immed hours after the allegs that cause the allegs serious bodily injury the events that cause abuse and do not rethe administrator of officials (including to adult protective service for jurisdiction in lonaccordance with Staprocedures.  §483.12(c)(4) Repoinvestigations to the designated represent accordance with Stasurvey Agency, with incident, and if the accordant in the stage of the sta | ding injuries of unknown opriation of resident property, iately, but not later than 2 lation is made, if the events ation involve abuse or result in a contract of the allegation do not involve esult in serious bodily injury, to the facility and to other of the State Survey Agency and vices where state law provides ageterm care facilities) in ate law through established |   |  |                |                            |  |

| AND DUAN OF CORRECTION IDENTIFICATION NUMBER |  | (X2) MULTIF   | PLE CONSTRUCTION  G | COMF  | (X3) DATE SURVEY COMPLETED |                            |
|--|--|---|---------------------|---|----------------------------|----------------------------|
|  |  | 375488  | B. WING             |   | I                          | C<br><b>/01/2021</b>       |
| NAME OF P                                    | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                       | , <u>v</u>                 | <u> </u>                   |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 609  | situation was deterr facility's failure to et allegations of abuse suspected and/or and A staff member allegations of abuse facility with holding #9. The allegation of administrator for invalidation of the administrator for invalidation of the acility docume being physically abuse reported by staff. Tresident, complete a implement corrected abuse.  Staff witnessed verification of the administrator time.  At 11:04 a.m., the Complete acility and the administrator time.  At 11:28 a.m., the Anotified of the IJ.  An acceptable plan the administrator or documented the followed. | mediate Jeopardy (IJ) mined to exist related to the naure staff reported immediately after identifying ctual abuse had occurred.  ged that LPN #3 had been g pain medications to resident was not reported timely to the restigation.  If being verbally abusive to 2/21 was not reported until after the allegation occured.  Inted an incident of resident #5 used by staff witnessed and the facility failed to protect the a thorough investigation and d measures to prevent further  Intel abuse to Resident #6, by reported it to the charge nurse, id not report the allegation to mely.  Intel and verified the situation.  Indicate the partment of a notified and verified the situation.  Intel and verified by Intel and the situation of the partment of the situation.  Intel and verified by Intel and the situation of the partment of the situation.  Intel and the partment of the situation of the partment of the situation.  Intel and the partment of the situation of the partment of | F 60                |   |                            |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | DF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                          | 1 ' '              |    | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|-------------------------------|--|--------------------|----|--|-------------------------------|----------------------------|
|                          |                               |  |                    |    |  | c                             |                            |
|                          |                               | 375488   | B. WING            |    |  | 07/                           | 01/2021                    |
| NAME OF PR               | ROVIDER OR SUPPLIER           |  |                    |    | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                            |
|                          |                               |  |                    |    | 301 SOUTH OAKWOOD ROAD   |                               |                            |
| THE COM                  | MONS                          |  |                    |    | ENID, OK 73706   |                               |                            |
|                          |                               |  |                    |    |  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)              | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 609                    | Continued From page           | e 66   | F                  | 60 | 9  |                               |                            |
|                          | staff on shift will be ed     | ducated on updated policy  |                    |    |  |                               |                            |
|                          |                               | ot currently working will be   |                    |    |  |                               |                            |
|                          | inserviced by phone of        | , ,  |                    |    |  |                               |                            |
|                          |                               | ched) (amended to be 9 am  |                    |    |  |                               |                            |
|                          | •                             | acted, we will document  |                    |    |  |                               |                            |
|                          |                               | e staff member will be taken   |                    |    |  |                               |                            |
|                          | off the schedule until        |  |                    |    |  |                               |                            |
|                          | The following texts wi        | •  |                    |    |  |                               |                            |
|                          |                               | ors have identified serious  |                    |    |  |                               |                            |
|                          | -                             | reporting. All staff are   |                    |    |  |                               |                            |
|                          |                               | in-service. Someone from   |                    |    |  |                               |                            |
|                          |                               | calling you before midnight  |                    |    |  |                               |                            |
|                          | tonightIf you have b          |  |                    |    |  |                               |                            |
|                          |                               | e by midnight, call [director  |                    |    |  |                               |                            |
|                          | of nursing] or will be r      | emoved from the  |                    |    |  |                               |                            |
|                          | scheduleBeginning             | IMMEDIATELY-reporting of   |                    |    |  |                               |                            |
|                          | ANY abuse allegation          | ns will be need to be texted   |                    |    |  |                               |                            |
|                          | or called to [administr       |  |                    |    |  |                               |                            |
|                          | _                             | s any time- DAY or NIGHT!  |                    |    |  |                               |                            |
|                          |                               | xt, then CALLAll staff that  |                    |    |  |                               |                            |
|                          |                               | as not timely reporting abuse  |                    |    |  |                               |                            |
|                          |                               | suspension. [Resident #5]  |                    |    |  |                               |                            |
|                          |                               | nysical abuse allegation will  |                    |    |  |                               |                            |
|                          |                               | iately. At every allegation of   |                    |    |  |                               |                            |
|                          |                               | sent to all staff to remind  |                    |    |  |                               |                            |
|                          |                               | se very seriouslyAn  |                    |    |  |                               |                            |
|                          |                               | eported, this is a reminder  |                    |    |  |                               |                            |
|                          |                               | ill be tolerated Administrator,  |                    |    |  |                               |                            |
|                          |                               | d DON have learned that a  |                    |    |  |                               |                            |
|                          |                               | n includes resident safe   |                    |    |  |                               |                            |
|                          | •                             | at the alleged abuser has  |                    |    |  |                               |                            |
|                          |                               | statements from those<br>included in an investigation.                         |                    |    |  |                               |                            |
|                          | <u> </u>                      |  |                    |    |  |                               |                            |
|                          | We have reviewed the          | e dillerent types and<br>nd will follow our policies                           |                    |    |  |                               |                            |
|                          | •                             | ed. We will in-service all   |                    |    |  |                               |                            |
|                          | -                             | attached education. We   |                    |    |  |                               |                            |
|                          |                               | ess is the person that has   |                    |    |  |                               |                            |
|                          | learned that the withe        | os is the herson that has  |                    |    |  |                               |                            |

| AND DIAM OF CODDECTION IDENTIFICATION NUMBED: |  | IPLE CONSTRUCTION  NG   |                     | ATE SURVEY<br>OMPLETED  |           |                            |
|---|--|---|---------------------|---|-----------|----------------------------|
|   |  | 375488  | B. WING _           |   |           | C<br>07/01/2021            |
| NAME OF P                                     | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                 |           | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 609   | reported the incident learned that to prope must conduct medic status assessment a assessment each shoccurrences"  On 06/28/21, six nur certified medication practical nurses (LPI (RN), seven houseked maintenance staff from interviewed and able related to abuse.  At 6:57 a.m., the AD did to further educate abuse. She stated soperations manual after administrator for if she shared that infladministrative staff. information themselves was anything specifical administrative staff of specific."  At 3:30 p.m., the addit an amended pladue to ongoing abus being reported timled conducting thorough.  An acceptable plan of the administrator on documented the follow.  "Plan of AMENDED" | during the investigation. We erly assess the resident we al, psychosocial, and mental at the time, and an iff for 3 days for 9  se aides (CNA), seven aides (CMA), six licensed N), one registered nurse expers and one om across all shifts, were at to state accurate information.  M was asked what the facility at the administrative staff on the looked through the state and reached out to some of the ums online. She was asked formation with her She stated they looked up wes. She was asked if there are they educated the on. She stated, "No, nothing ministrator was made aware on of removal was needed e and neglect allegations not and investigations.  of removal was provided by 06/29/21 at 7:20 p.m. It | F6                  | 509   |           |                            |

|                          | DEFICIENCIES CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING  |                     |  | (X3) DATE SURVEY COMPLETED     |                            |
|--------------------------|--|---|---------------------|--|--------------------------------|----------------------------|
|                          |  | 375488  | B. WING             |  |                                | C<br>07/04/2024            |
| NAME OF PI               | ROVIDER OR SUPPLIER  | 0.0400  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706  | DDE                            | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE CORRECTION OF CO | ON SHOULD BE<br>HE APPROPRIATI | (X5)<br>COMPLETION<br>DATE |
| F 609                    | 2021 [By 8:00 p.m.] Misappropriation InveupdatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the ADON [assistant directors outside agency. Due 06/28/21 [staff name [CNA #6] and [LPN #6/30/21  An ADMINISTRATIVE the INCIDENT RESP and includes the Administrator, DON, ACEnter Resident service administrator or design Director any allegation scheduled monthly mincipental minimum scheduled monthly minimum scheduled | Abuse, Neglect, estigation POLICY was agency will provide is needed] pain medication A, and Nursing on June will focus on neglect, and not ons. All staff that have not une 30th, 8pm may not work the DON [director of nursing], or the to further consideration on deleted] was terminated.  E team was formed called ONSE TEAM on June 29th, inistrator, Assistant ADON, and HealthCare inces Director. The gnee will report to Board of in of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ing, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and is to ensure all thorough | F6                  | 509  |                                |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|-----------------------------|--|-------------------------------|--|
|                          |   | 375488  | B. WING                     |  | C<br>07/01/2021               |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                             | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                                  | 1 0770172021                  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETION               |  |
| F 609                    | Continued From pa   | ge 69   | F 609                       |  |                               |  |
|                          | of 06/30/21 at 5:10 plan of removal and had been implement remained at a level.  Based on record resinterviews, it was deen sure staff reported immediately after id abuse had occurred six sampled resider.  The facility identifies facility.  Findings:  An abuse policy, da "Reporting Require reported immediate and to other officials law. Allegations that reported within 2 hose thoroughly invest further potential aburther potential aburther potential aburther potential aburther potential aburther potential aburther eafter, regardin abuse, neglectAll upon first employment thereafter, regardin abuse, neglect or many supervisorThe supervisorThe supervisorThe supervisorThe supervisorThe supervisor | pardy deficiency was lifted as p.m. when all elements of the difference to the amended plan of removal nated. The deficient practice of actual harm at a pattern.  View, resident and staff etermined the facility failed to ad allegations of abuse lentifying abuse/suspected differ four (#5, 6, 7 and #9) of nats reviewed for abuse.  In the deficient practice of actual harm at a pattern.  Attending the facility failed to ad allegations of abuse lentifying abuse/suspected differ four (#5, 6, 7 and #9) of nats reviewed for abuse.  In the facility staff with state at involve administrator, DON is in accordance with State at involve abusemust be boursThese allegations must be stigated and must prevent use while the investigation is in attending action must be taken the appropriate licensingIt [sic] the policy of The in resident will be free from facility staff will be in-serviced ent, and at least annually gneglect or y report any suspicion of nistreatment to your immediate pervisor WILL CALL the CELL NISTRATOR [admin], then the |                             |  |                               |  |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--|-----|--|-------------------------------|----------------------------|
|   |  | 375488  | B. WING                                |     |  | 07/                           | 01/2021                    |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |  | 30  | REET ADDRESS, CITY, STATE, ZIP CODE  1 SOUTH OAKWOOD ROAD  NID, OK 73706   | 077                           | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 609   | state agencies, law e families, and/or reside subject of abuse shal discussedInvestigat for, treat and PROTE ADON, or house supeassessment immedia in detailTake a state resident2ndIsolateImmediately notify t"  1. Resident #9 had dechronic pain and oste A resident assessment documented the residenderately impaired.  A care plan, effective "Resident is at risk muscle spasms and esyndromeResident treated/relieved in a temedications as presed Physician's orders, da "hydrocodone 7.5 mg 325 mg tablet (Norco every 8 hours as need Tylenol 325 mg capstroute every 6 hours as Ultram 50 mg tablet groute every 6 hours as need to supper super | espective agencies such as inforcement, physician; ent responsible party. The I be routinely and openly tionProcedure1stCare CT the resident-DON, ervisor should do a medical telydocumenting any injury ement from the e the perpetrator3rd the Administrator, then DON diagnoses which included coarthritis.  Int, dated 01/14/21, dent's cognition was date 01/07/21, documented, for pain r/t [related to] chronic pain will have pain imely mannerAdminister ribed"  Intel of 06/08/21, documented, in [milligrams]-acetaminophen in give 1 tablet by oral route ded FOR CHRONIC PAIN  Lated 06/08/21 tablets by oral is needed for pain | F                                      | 609 |  |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G  | , ,      | ATE SURVEY<br>MPLETED      |
|--------------------------|---|--|---------------------|--|----------|----------------------------|
|                          |   | 375488   | B. WING             |  |          | C<br>07/01/2021            |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | <u>`</u> | 3770 172021                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 609                    | on multiple occasion: thing in the morning at line in the morning ask for a pain pill. However, and the pain in the pain to request to the charge go to the resident to report back to me, the administer a pain melevel of the pain that location of the pain meds at doesn't need a pain pain smoke a cigarette, he he can go outside to pain pill because he On these occurances pain meds until some p.m. as reflected on administration record.  An OSDH incident for documented, "[Resent Abuse/Mistreatment. IncidentStaff report pain meds when resine Resident is cognitive called"  A statement from LP 12:23 [did not documented, "Some pills when it is not time is scheduled [every] | atted, "Generally every day, so, typically beginning first after the CNA has helped out of bed for the day, he will be will specifically ask for a sain at an 8 out of 10 for leg or ol, as the CMA, I report the enurse, the charge nurse will evaluate the resident and the economic control of the control of t | F 60                | 09   |          |                            |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDII | FIPLE CONSTRUCTION  NG   |                                  | ATE SURVEY<br>DMPLETED     |
|--------------------------|--|---|-------------------------|--|----------------------------------|----------------------------|
|                          |  | 375488  | B. WING _               |  |                                  | C<br>07/01/2021            |
| NAME OF PE               | ROVIDER OR SUPPLIER  |   |                         | STREET ADDRESS, CITY, STATE, ZIP C<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706 |                                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG     | · ·  | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 609                    | Continued From pag   | ge 72   | F 6                     | 609  |                                  |                            |
|                          |  | conducted with five residents.  d to the residents were not pain medications.   |                         |  |                                  |                            |
|                          | _  | nted the allegation was<br>I completed on 06/27/21 at   |                         |  |                                  |                            |
|                          | The employee conti investigaion of the a   | nued to work during the<br>lleged negelct.  |                         |  |                                  |                            |
|                          |  | erview residents and staff to victim regarding pain   |                         |  |                                  |                            |
|                          | assistant administrate conclusion of the invadministrator stated spreadsheet of which versus the Norco. Shad administered the other nurses. She was documentation of the requested the Norco you could tell when asked if there was no resident requested in withheld the medical conclusion the alleg. She stated she wen | 0 p.m., the administrator and tor were asked about the vestigation. The assistant she had made an excelch nurse had given Tylenol She stated the accused nurse e medications as much as the vas asked if there was e times the resident had b. She stated she didn't think he had requested it. She was to documentation of when the t and the CMA stated LPN #3 tion, how did they come to the ation was unsubstantiated. It to the resident and asked ated the resident is this erleader. |                         |  |                                  |                            |
|                          | There were no ques related to staff withh  | M provided resident surveys.<br>tions asked to the residents<br>olding pain medications. She<br>director had made the   |                         |  |                                  |                            |

|                          | OF DEFICIENCIES  CORRECTION  |   |                     |  | COMPLETED |                            |
|--------------------------|--|---|---------------------|--|-----------|----------------------------|
|                          |  | 375488  | B. WING _           |  |           | C<br><b>07/01/2021</b>     |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                        |           | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 609                    | surveys and thought members respect you make decisions regard that.  On 06/29/21 at 6:35 pif he was in pain. He right side, leg and known rate it at an 8 out of 1 a 9 in the mornings. he did not get his North He stated, "If I don't gwas asked if his North Stated it was and the disclose who the empredication.  At 7:02 p.m., CMA #3 allegations made reg Norco. She stated, "It the time." She stated because when he as protocol I have to followould give the same in her statement. She take their pain as the #3 would have her act instead of the Norco.  2. Resident #7 was a diagnoses which including anxiety disorder.  A quarterly resident a documented the residing aired.  A state incident reporting the state incident reporting and the state incident reportin | that the question "Do staff ar requests and allow you to rding your care" covered on.m., the resident was asked stated he had pain in his ee. She stated he would 0. He stated it was usually He was asked how he felt if the roo when he requested it. I get them, I get mad." He was ever withheld. He is stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he would not ployee was that withheld the stated he was asked about the stated he was asked he was | F 6                 | 09   |           |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:  |                    | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |          | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--------------------|--|--|----------|-------------------------------|--|
|   |  | 375488  | B. WING            |  |  | l        | 01/ <b>2021</b>               |  |
| NAME OF PR  | ROVIDER OR SUPPLIER  |   |                    | 3                                      | TREET ADDRESS, CITY, STATE, ZIP CODE<br>01 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                              | <u> </u> | ·                             |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | X                                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |          | (X5)<br>COMPLETION<br>DATE    |  |
| F 609   | allegation of verbal al from a staff member a is not on the schedule not be working until the investigated. Investig day and final reports, of the investigation a implemented to preveattached for investigatesident. She was suways to recognize but a Employee Assistance. The allegation of abut administrator until the The facility failed to rewithin two hours to the as the Oklahoma Stato (OSDH).  A written statement be documented, "The daspent a majority of the hallway outside of [ar approximately 2 p.m. himself in his wheeled station area and park outside of the wound Immediately the chartant yelled to [resident here, you're not going here." [Resident #7] yelled at [LPN #3]. It at her, his speech is to health conditions. | Description of or was notified today of an ouse occurring on 02/22/21 against a nurse. The nurse is until Thursday. She will me allegation has been pation is in progressFor 5 please include a summary and corrective measures ant recurrenceSee tion: Nurse yelled at aspended and counseled on arrout. Also gave her information"  See was not reported to the enext day after it occurred.  Report the allegation of abuse appropriate agencies such the Department of Health  Of CMA #3, dated 02/23/21, by of 2-22-21, [resident #7] are day sitting in the North Hall nother resident]s room. At a [resident #7] wheeled the nair up closer to the nurse's agenties and in the North hall nother the nurse is the day wheelchair in his wheelchair | F                  | 609                                    |  |          |                               |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |           |   | (X3         | ) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|-----------|---|-------------|----------------------------|
|                          |  | 375488   | B. WING _ |   |             | C<br><b>07/01/2021</b>     |
|                          | PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING  B. WING  ME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706  X4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REFIX  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  101  102  103  104  105  105  106  107  107  107  108  108  109  109  109  109  109  109   |  |           |   |             | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | PREFIX    | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | I SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 609                    | talk to me that way." [resident #7] wheele nurse's station area his roomDuring thi sitting in a chair besi entire event"  A written statement I documented, "On M #4] came into work I sitting at nurses stat came strolling up to nurses station [LPN around and go back said I dont care Im n and he said he want screamed at him and your [sic] not sitting I deal with your Ass. s Corner til [LPN #3] I of the evening"  A written statement I documented, "The o getting something w at [resident #7]. And [Resident #7] started #3] got louder and to listen to it. Go to you Im sick of him acting  A investigative summ "When did the inci on Feb [February] 22 | After this occurrence, d himself away from the back down the hall towards is occurrence, [CMA #4] was ide me and witnessed the occurrence, [CMA #4] was ide me and witnessed the occurrence, [CMA #4] was ide me and witnessed the occurrence, [CMA #4] was ide me and witnessed the occurrence, [CMA #4] was on North Hall. I was identify the resident the Common Area by the find the common Area by the said he has rights She of gonna [sic] deal with you ed to sit up here She identify and in the said "I dont give a dam [sic] up here Im not gonna [sic] are fresident #7] sat in the eff he was very upset the rest occurrence of the was very upset the rest occurrence of the said "I dont give a dam [sic] are find the was very upset the rest occurrence of the was very upset the rest occurrence of the was in the office then I heard [LPN #3] yelling it telling him to go to his room. It yelling back at her and [LPN bold him she wasn't going to our room. [LPN #3] then said a like this" | F 6       | 609   |             |                            |
|                          |  | p.m., the admin was asked eport suspected abuse to.  |           |   |             |                            |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  IG  |          | ATE SURVEY<br>DMPLETED     |
|--------------------------|--|--|--------------------------|---|----------|----------------------------|
|                          |  | 375488   | B. WING _                |   |          | C<br>07/01/2021            |
| NAME OF PE               | ROVIDER OR SUPPLIER  |  |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706               |          | 0170172021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 609                    | the staff had witnes timely. She stated, staff who witnessed about reporting time writing."  On 06/24/21 at 1:09 verbal abuse happed p.m. She stated "You continued to work a was asked if LPN # residents, how were stated," They could about it." She was report the abuse improtected. She staff members not immediately repworked with the vict approximately four 13. Resident #5 was diagnoses which incomplete the resident documented the residally decision making the staff which will be staff to the staff members and the staff members are staff members and immediately repworked with the vict approximately four the staff members and immediately repworked with the vict approximately four the staff members and immediately resident documented the residually decision making the staff which will be staff as the staff will be staff as the staff will be staff as the staff which will be staff as the staff will be staff as the staff which will be staff as the staff which will be staff as the staff will be staff wil | thority." She was asked when sed the abuse, did they report "No." She was asked if the the abuse were inserviced ely. She stated, "Nothing in "P. p.m., the DON was asked if ened on 02/22/21 around 2:00 es." She was asked if LPN #3 fter. She stated, "Yes." She acontinued to work with the the resident protected. She in the because we didn't know asked, since the staff failed to mediately, were the residents ed, "No."  Who witnessed the abuse did out it. As a result, LPN #3 im and other residents for hours and 48 minutes.  admitted to the facility with cluded dementia.  assessment, dated 05/02/21, sident's cognitive skills for ing was severely impaired. | F 6                      |   |          |                            |
|                          | documented, "Re<br>#5]Incident Type<br>Abuse/Mistreatmen<br>IncidentReceived<br>towards a resident I<br>member suspended   |  |                          |   |          |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|-----------------------|---|-------------------------------|----------------------------|--|
|  |   | 375488   | B. WING _             |   |                               | C<br>07/01/2021            |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                     |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG   | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |  |
| F 609  | #2] asked me if I cover yes just give me a semiddle of taking care. I walked into [reside ahold [sic] of his Rigon him while she was bare skin I yelled away [and] she was lidropped him back on his arm to get him u would take care of his breakfast [and] told just happened. When #2] she told her to semi [10:00 a.m.] I asked [and] I told [DON] where she was not awasked me to write out A written statement documented, "[CMA yelled at [CNA #2] be me to help get him [room where she was at his left leg so I told finish him, I went to happened she said never hurt anyone we room"  An investigative sun "When did the inciam.]When was fallowed. | ded "Around [8:30 a.m.] [CNA and come help her I told her becond because I was in the er of another Resident. When in the set of another Resident. When in the the set of another Resident. When in the set of another I pulling is slapping at his left leg,-on at her to stop doing him that ke what [and] just kind of in the bed, she went to pull on politor I told her to just leave that I im. I brought him out for the Charge Nursewhat had en [LPN #2] talked to [CNA tay away from direct care of I seen [sic] D.O.Naround if [LPN #2] had talk to her that had happened She told are but now she is [and] at a statement"  In the thick the thick the second of | F                     | 609   |                               |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|---|----------------------------|
|                          |  | 375488   | B. WING             |   | 07/01/2021                 |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             | 1 07/01/2021               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETION         |
| F 609                    | the incident in a time  LPN #2 did not repor immediately and as a work with other resid and a half to two and  4. Resident #6 had d Huntington's disease  A resident assessme documented the resi  A nurse's note, dated documented, "Reside back"  An initial OSDH incid documented, "Alled MistreatmentDescr IncidentAdministra director that activity a statement, that she of F******* Christ, [Reside notified he had fallen The nurse is suspend complete" A facsir documented the repo 03/22/21 at 4:22 p.m.  On 06/24/21 at 1:35 was reported timely, notified until the next  On 06/25/21 at 3:09 asked who she had re- | It incident to the DON a result, CNA #2 continued to ents for approximately one a half hours.  In a ha | F 60                | 09  |                            |

|                          | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   |                     | (X3) DATE SURVEY COMPLETED   |          |                            |
|--------------------------|---|---|---------------------|--|----------|----------------------------|
|                          |   | 375488  | B. WING             |  |          | C<br>07/01/2021            |
| NAME OF PI               | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706              | '        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 609                    | Continued From pagand that her supervise  | e 79<br>or was going to call the  | F 60                | 09   |          |                            |
| F 610<br>SS=K            | administrator.<br>Investigate/Prevent/0<br>CFR(s): 483.12(c)(2)   | Correct Alleged Violation<br>-(4)   | F 6 <sup>2</sup>    | 10   |          |                            |
|                          | , , , ,   | se to allegations of abuse, or mistreatment, the facility   |                     |  |          |                            |
|                          | §483.12(c)(2) Have e<br>violations are thorou   | evidence that all alleged ghly investigated.  |                     |  |          |                            |
|                          |   | nt further potential abuse,<br>or mistreatment while the<br>ogress.   |                     |  |          |                            |
|                          | designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT by:  On 06/25/21, an Immistration was determined to the state of the | the results of all administrator or his or her tative and to other officials in the law, including to the State on 5 working days of the leged violation is verified to action must be taken.  I is not met as evidenced to the state of the leged with the leged violation is verified to exist related to the state of the |                     |  |          |                            |
|                          | had been conducted  | and appropriate corrective or allegation of abuse.  |                     |  |          |                            |
|                          | refusing/withholding<br>#9. The allegation w<br>administrator and a t<br>not conducted. The e   | ed that LPN #3 had been pain medications to resident as not reported timely to the horough investigation was employee remained working on and no action was taekn   |                     |  |          |                            |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G   |          | ATE SURVEY<br>DMPLETED     |
|--------------------------|---|--|---------------------|---|----------|----------------------------|
|                          |   | 375488   | B. WING             |   |          | C<br>07/04/2024            |
| NAME OF PI               | ROVIDER OR SUPPLIER   | 1 0.0.00   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                     | <u> </u> | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SHI  CROSS-REFERENCED TO THE APP  DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 610                    | Continued From pag  | e 80   | F 6                 | 10  |          |                            |
|                          | resident #7 on 02/22<br>02/23/21, one day af  | being verbally abusive to /21 was not reported until ter the allegation occurred. not protected as the staff to work.  |                     |   |          |                            |
|                          | being physically abureported by staff. The resident, complete a                                 | ted an incident of resident #5<br>sed by staff witnessed and<br>he facility failed to protect the<br>thorough investigation and<br>measures to prevent further |                     |   |          |                            |
|                          |   |  |                     |   |          |                            |
|                          | an employee and rep<br>not reported to the a<br>thorough investigation<br>residents were not po | g at work and continued to   |                     |   |          |                            |
|                          |   | klahoma State Department of notified and verified the tuation.   |                     |   |          |                            |
|                          | At 11:28 a.m., the Ac<br>notified of the IJ.  | lministrator (ADM) was   |                     |   |          |                            |
|                          |   | of removal was provided by<br>06/25/21 at 9:55 p.m. It<br>owing:   |                     |   |          |                            |
|                          | "All residents will be  | interviewed 06/25/2021. All  |                     |   |          |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1 |                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                          | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |         |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---------------------------|--|---|---------|---|-------------------------------|----------------------------|
|   |                           |  |   |         | С   |                               |                            |
|   |                           | 375488   | B. WING                                 | B. WING |   | 07/                           | 01/2021                    |
| NAME OF PR  | ROVIDER OR SUPPLIER       |  |   |         | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
|   |                           |  |   |         | 301 SOUTH OAKWOOD ROAD  |                               |                            |
| THE COM   | MONS                      |  |   |         | ENID, OK 73706  |                               |                            |
|   |                           |  |   |         |   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC)          | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG                      |         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 610   | Continued From page       | e 81   | F                                       | 610     | 0   |                               |                            |
|   | staff on shift will be ed | ducated on updated policy  |   |         |   |                               |                            |
|   |                           | ot currently working will be   |   |         |   |                               |                            |
|   | inserviced by phone of    |  |   |         |   |                               |                            |
|   |                           | ched) (amended to be 9 am  |   |         |   |                               |                            |
|   |                           | acted, we will document  |   |         |   |                               |                            |
|   |                           | e staff member will be taken   |   |         |   |                               |                            |
|   | off the schedule until    |  |   |         |   |                               |                            |
|   | The following texts wi    | •  |   |         |   |                               |                            |
|   |                           | ors have identified serious  |   |         |   |                               |                            |
|   | •                         | reporting. All staff are   |   |         |   |                               |                            |
|   |                           | in-service. Someone from   |   |         |   |                               |                            |
|   |                           | calling you before midnight  |   |         |   |                               |                            |
|   | tonightIf you have b      |  |   |         |   |                               |                            |
|   |                           | e by midnight, call [director  |   |         |   |                               |                            |
|   | of nursing] or will be r  | emoved from the  |   |         |   |                               |                            |
|   | scheduleBeginning         | IMMEDIATELY-reporting of   |   |         |   |                               |                            |
|   | ANY abuse allegation      | ns will be need to be texted   |   |         |   |                               |                            |
|   | or called to [administr   | ator][assistant  |   |         |   |                               |                            |
|   | _                         | s any time- DAY or NIGHT!  |   |         |   |                               |                            |
|   |                           | xt, then CALLAll staff that  |   |         |   |                               |                            |
|   |                           | as not timely reporting abuse  |   |         |   |                               |                            |
|   |                           | suspension. [Resident #5]  |   |         |   |                               |                            |
|   |                           | nysical abuse allegation will  |   |         |   |                               |                            |
|   |                           | iately. At every allegation of   |   |         |   |                               |                            |
|   |                           | sent to all staff to remind  |   |         |   |                               |                            |
|   |                           | se very seriouslyAn  |   |         |   |                               |                            |
|   |                           | eported, this is a reminder  |   |         |   |                               |                            |
|   |                           | ill be tolerated Administrator,  |   |         |   |                               |                            |
|   |                           | d DON have learned that a  |   |         |   |                               |                            |
|   |                           | n includes resident safe   |   |         |   |                               |                            |
|   |                           | at the alleged abuser has  |   |         |   |                               |                            |
|   |                           | statements from those  |   |         |   |                               |                            |
|   | · ·                       | included in an investigation.  |   |         |   |                               |                            |
|   | We have reviewed the      | * ·  |   |         |   |                               |                            |
|   | •                         | nd will follow our policies  |   |         |   |                               |                            |
|   |                           | ed. We will in-service all attached education. We                              |   |         |   |                               |                            |
|   |                           | ess is the person that has   |   |         |   |                               |                            |
|   | icamed mat me withe       | so io tile person that has   |   |         |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '  | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED  |  |            |
|---|---|--|---------------------|---|--|------------|
|   | 375488 B. WING  |  |                     |   | C<br><b>07/01/2021</b>   |            |
| NAME OF PE  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706 |  | 07/01/2021 |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHO   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |            |
| F 610   | reported the incident learned that to proper must conduct medical status assessment at assessment each shi occurrences."  On 06/28/21, six nurse certified medication a practical nurses (LPN (RN), seven houseke maintenance staff frointerviewed and able related to abuse.  At 6:57 a.m., the ADN did to further educate abuse. She stated shoperations manual ar her administrator forcif she shared that info administrative staff. Sinformation themselve was anything specific administrative staff or specific."  The facility reported reallegation of rape by staff contnued to wor allegation. A staff methad been refusing/wit to resident #9. The attimely to the administrinvestigation was not | during the investigation. We rly assess the resident we l, psychosocial, and mental the time, and an ft for 3 days for 9  The aides (CNA), seven ides (CMA), six licensed l), one registered nurse epers and one m across all shifts, were to state accurate information  The was asked what the facility the administrative staff on the looked through the state and reached out to some of the state and reached out to some of the state and reached out to some of the state and reached they looked up the state and they looked up the stated they looked up the stated they looked the they educated the late. She stated, "No, nothing the staff on 06/28/21 and the k over six hours after the ember alleged that LPN #3 thholding pain medications illegation was not reported rator and a thorough | F 6                 |   |  |            |
|   | that an amended plar  | n of removal was needed<br>e and neglect allegations   |                     |   |  |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIF  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED  |            |  |
|--|---|--|---------------------|---|--|------------|--|
| 375488 B. WING   |   | 07/01/2021   |                     |   |  |            |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706 |  | 0770172021 |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |            |  |
| F 610  | thorough investigated An acceptable plant the administrator of documented the form. "Plan of AMENDED THESE items will be 2021 [By 8:00 p.m. Misappropriation In updatedAn outside in-service on PRN administration for 030th. This inservice withholding medicabeen in serviced by until in serviced, by ADON [assistant dioutside agency. Die 06/28/21 [staff name [CNA #6] and [LPN 06/30/21  An ADMINISTRATI the INCIDENT RESTANT and includes the Acceptant of the Acc | residents and conducting rions.  of removal was provided by n 06/29/21 at 7:20 p.m. It llowing:  O Removal for IJ's - ALL re completed by June 30th, | F 6                 | 10  |  |            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '   | PLE CONSTRUCTION  B | (X3) DATE SURVEY COMPLETED  |                    |
|---|--|---|---------------------|---|--------------------|
|   |  | 375488  | B. WING             |   | 07/01/2021         |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706                           | 1 07/01/2021       |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETION |
| F 610   | respond to allegation investigation has been on 07/01/21, two LP were interviewed and information related to administrative staff wable to state accurate abuse and neglect.  The immediate jeoper of 06/30/21 at 5:10 pplan of removal and had been implement remained at a level of Based on record revinterviews, it was determined and was a level of the completed and was a level of the complete of th | s to ensure all thorough  | F 61                | 0   |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIF  | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED  |                   |
|--|---|--|---------------------|---|-------------------|
| 375488 B. WING   |   |  | C<br>07/01/2021     |   |                   |
| NAME OF PI   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                               | 1 07/01/2021      |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE COMPLETION |
| F 610  | progressappropria including report to the boardPrevention Commons that each abuse, neglectAll upon first employmenthereafter, regarding abuseImmediately abuse, neglect or mentions of the ADMIN DONSuspected of also be reported to restate agencies, law families, and/or resides ubject of abuse shad discussedInvestigation, treat and PROT ADON, or house suppressed in detailTake a state resident2ndIsolationImmediately notify"  1. Resident #9 had chronic pain and ost A resident assessment documented the resident assessment impaired. A care plan, effective "Resident is at risk at resident is at resident is at resident is at resident is at resident in the resident is at resident is at resident in the r | se while the investigation is in the action must be taken the appropriate licensing and the second stream of the aresident will be free from facility staff will be in-serviced ent, and at least annually gamelect or a report any suspicion of interestment to your immediate pervisor WILL CALL the CELL HISTRATOR [admin], then the resubstantiated cases must respective agencies such as enforcement, physician; then the responsible party. The fall be routinely and openly actionProcedure1stCare ECT the resident-DON, pervisor should do a medical atelydocumenting any injury tement from the state the perpetrator3rd of the Administrator, then DON diagnoses which included the action of the second s | F 61                |   |                   |
|  | muscle spasms and<br>syndromeResiden<br>treated/relieved in a<br>medications as pres  | t will have pain<br>timely mannerAdminister  |                     |   |                   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY COMPLETED   |                        |  |
|---|---|---|---------------------|--|--|------------------------|--|
|   |   | 375488  | B. WING _           |  |  | C<br><b>07/01/2021</b> |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | 1   |                     | STREET ADDRESS, CITY, STATE, ZIP 301 SOUTH OAKWOOD ROAD ENID, OK 73706 | CODE   | 07/01/2021             |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                        |  |
| F 610   | Continued From pag  | e 86  | F 6                 | 610  |  |                        |  |
|   | "hydrocodone 7.5 mg 325 mg tablet (Norco every 8 hours as need a pain pill because he Con these occurrence pain meds until some p.m. as reflected on administration record. | give 1 tablet (50 mg) by oral as needed for pain"  MA #3, dated 06/26/21 at nted, "Generally every day, s, typically beginning first after the CNA has helped out of bed for the day, he will e will specifically ask for a ain at an 8 out of 10 for leg or ol, as the CMA, I report the e nurse, the charge nurse will evaluate the resident and the CMA, with guidance to be and instruct me with the was reported and the in. On many occurrences, he resident, [Resident's ating 'He just got up, he pill' or 'He's going outside to be's not hurting bad enough if smoke' or 'He can't have a hasn't eaten anything yet.' bes, [Resident] won't receive etimes 10 a.m. or as late a 2 the MAR [medication d]" |                     |  |  |                        |  |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` ′                |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|--------------------|-----|--|-------------------------------|----------------------------|
|   |   | 375488   | B. WING            |     |  | C<br>07/01/2021               |                            |
| NAME OF PI  | ROVIDER OR SUPPLIER   |  | -                  | 3   | STREET ADDRESS, CITY, STATE, ZIP CODE 601 SOUTH OAKWOOD ROAD ENID, OK 73706                                  | 1 077                         | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 610   | pain meds when resided Resident is cognitive called"  A statement from LPN 12:23 [did not documented, "Someting pills when it is not time is scheduled [every] & offered Tylenol if Nord Safe surveys were confided to receiving particular to rece | Description of ed Nurse not approving PRN dent asked for them. and needs no family  N #3, dated 06/27/21 at ent a.m. or p.m.], imes resident asks for pain e as he had it earlier. Med B [hours] prn. Resident is co can't be given yet"  Inducted with five residents. to the residents were not ain medications.  ed the allegation was completed on 06/27/21 at edged neglect.  Implete a thorough riew residents and staff to etim regarding pain entheld.  In p.m., the administrator and or were asked about the estigation. The assistant the had made an excel nurse had given Tylenol are stated the accused nurse medications as much as the | F                  | 610 |  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED   |          |                            |
|--|---|--|---------------------|--|----------|----------------------------|
| 375488   |   | B. WING  |                     | C<br>07/01/2021  |          |                            |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706        |          | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |                     | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 610  | asked if there was resident requested withheld the medica conclusion the alleg She stated she wer him about it. She s nurse's biggest che  At 1:19 p.m., the AI There were no ques related to staff with stated the executive surveys and though members respect yemake decisions reg that.  On 06/29/21 at 6:35 if he was in pain. Hright side, leg and krate it at an 8 out of a 9 in the mornings he did not get his NH e stated, "If I don't was asked if his No stated it was and the disclose who the emedication.  At 7:02 p.m., CMA allegations made re Norco. She stated, the time." She stated because when he a protocol I have to fo would give the sam in her statement. S | he had requested it. She was no documentation of when the it and the CMA stated LPN #3 ation, how did they come to the lation was unsubstantiated. It to the resident and asked tated the resident is this | F 6                 | 10   |          |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ,   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |           | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|--|--|-----------|-------------------------------|--|
|  |   | 375488  | B. WING                                |  |           | C<br>07/01/2021               |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706           |           | 7770 17202 1                  |  |
| (X4) ID<br>PREFIX<br>TAG   |   |   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 610  | 4   |   | F 61                                   | 0  |           |                               |  |
|  | instead of the Norco  2. Resident #7 was a diagnoses which inclanately disorder.  A quarterly resident a documented the resimpaired.  A state incident reports documented, "IncidentAdministrational allegation of verbal afrom a staff member is not on the schedurnot be working until investigated. Investigated. Investigated. Investigated and final reports of the investigation implemented to prevattached for investigatent. She was sways to recognize be the Employee Assistance.  The facility failed to rewithin two hours to the statement of the complete th | admitted to the facility with luded convulsions and assessment, dated 02/18/21, dent's cognition was severely ort form, dated 02/23/21, dent TypeAllegations ofDescription of tor was notified today of an abuse occurring on 02/22/21 against a nurse. The nurse le until Thursday. She will the allegation has been gation is in progressFor 5, please include a summary and corrective measures ent recurrenceSee ation: Nurse yelled at uspended and counseled on urnout. Also gave her |  |  |           |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ` ′   | PLE CONSTRUCTION  B | (X3) DATE SURVEY COMPLETED   |                   |
|---|---|---|---------------------|--|-------------------|
|   |   | 375488  | B. WING             |  | C<br>07/01/2021   |
| NAME OF P   | ROVIDER OR SUPPLIER   | 20000   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                                | 07/01/2021        |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION |
| F 610   | outside of the wound Immediately the char and yelled to [reside here, you're not goin here." [Resident #7] yelled at [LPN #3]. I at her, his speech is to health conditions. again "get the hell outalk to me that way." [resident #7] wheeled nurse's station area his roomDuring this sitting in a chair besidentire event"  A written statement is documented, "On Mo #4] came into work I sitting at nurses static came strolling up to nurses station [LPN around and go back said I dont care Im nurses and he want screamed at him and your [sic] not sitting to deal with your Ass. so Corner til [LPN #3] led of the evening"  A written statement is documented, "The or getting something what [resident #7] started #3] got louder and to got the statement is documented, "The or getting something what [resident #7] started #3] got louder and to go the statement is got louder and to got louder and to got louder and t | ded himself in his wheelchair care nurse's office.  Ige nurse, [LPN #3], stood up nt #7] "get the hell out of g to sit up here while I'm did raise his hands and do not know what he yelled often hard to make out due [LPN #3] then yelled at him ut of here, you're not going to After this occurrence, d himself away from the back down the hall towards is occurrence, [CMA #4] was de me and witnessed the occurrence, I [CMA was on North Hall. I was on [resident #7] the resident the Common Area by the #3] the nurse told him to turn he said he has rights She ot gonna [sic] deal with you | F 61                |  |                   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION G  |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|---------------------|---|-------------------------------|----------------------------|
| 375488  |   |   | B. WING _           |   | 07/01/2021                    |                            |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                     | <b>'</b>                      | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 610   | Im sick of him acting A written statement of 5:00 p.m., document [administrator (administrator yellin) Monday February 22 [approximately] [2:00 [administrator yellin] Monday February 22 [approximately] [2:00 [administrator yellin] In the man but suppose [administrator yellin] It to the man but suppose [administer yellin] It to the man but suppose [administer yellin] It to the man but suppose [administer yellin] It to the man but suppose | by LPN #3, dated 02/24/21 at ted, "Missed a call from n) [at] the Commons. Called there was an allegation g [at] a male on North Hall on 2nd [at] approx 0 p.m.]Not only did I yell [at] edly I cussed [at] him also per eras. No AudioWas also ent to go away, go down the n. I had asked residents not wound care Nurse's office as ayMay of raised my voice"  hary, undated, documented, corted victim[resident reported perpetrator[LPN the incident[CMA #3],What twas in his wheelchair e's desk. [LPN #3] the nurse and started yelling at him to at is the history of the e incident foreseeableThe dere should yell at a resident. ald Never yell at resident, but foreseeableWhat does the en[resident #7] would not but when asked what he in, he just shrugged his the incident happenAround ary] 22ndWhen was facility ment staff first contacted | F 6                 |   |                               |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--|--|---|-------------------------------|----------------------------|
|   |  | 375488  | B. WING                                | B WING   |   | C                             |                            |
| NAME OF PI  | ROVIDER OR SUPPLIER  | 313400  | 2                                      | S<br>3   | TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH OAKWOOD ROAD ENID, OK 73706 | <u> </u>                      | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |  | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) |   |                               | (X5)<br>COMPLETION<br>DATE |
| F 610   | submitted date 02/26, Name: [LPN #3]Did or Criminal Behavior. abuseDescription or suspended pending the returned to work on 0 disciplinary action writed a resident and for concontrary to recognized employment at the fact A time sheet for pay proceed to the p.m. on 02/22/21. LP 4 hours and 48 minuted The facility failed to proceed to the administrator and was not completed.  On 06/23/21 at 2:24 proceed to describe the incident of the didn't yell. She stated took statements from and discussed the incident of the stated she was notified was asked what the cown was she stated it was did it. She stated she was stated she was did it. She stated she was did it. | of Nursing complaint form, /21, documented, "Nurse's incident include MisconductYes: Patient f InvestigationLPN was he investigation and 2/26/2021. She received te up for raising her voice at inducting herself in a manner d standards. Her cility is being retained"  Deriod from 02/14/21 to d LPN #3 worked til 6:48 PN #3 worked approximately es after the abuse occurred.  Protect residents from further estigation.  Report the allegation timely to a thorough investigation. | F                                      | 610  |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′   | PLE CONSTRUCTION  G | , ,  | (X3) DATE SURVEY COMPLETED |                            |
|---|---|---|---------------------|--|----------------------------|----------------------------|
|   |   | 375488  | B. WING             |  |                            | C<br><b>07/01/2021</b>     |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          |                            | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | IOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 610   | tolerance for abuse. hand book is wrong.' done to protect and pto other residents. Sanything else other the was asked who the sabuse to. She stated asked when the staff did they report timely asked if the staff who in serviced about rep."Nothing in writing."  On 06/24/21 at 1:09 verbal abuse happer p.m. She stated "Ye continued to work aff was asked if LPN #3 residents, how were stated," They couldn about it." She was a report the abuse imm protected. She stated The ADM was asked after the incident. She taff members we not immediately repoworked with the victing approximately four hor place to prevent aburesult, one of the with allegation of verbally The facility substanti | She stated, "If I say yes, my She was asked what was brevent this from happening the stated they didn't add than what was in place. She staff can report suspected d, "Any authority." She was thad witnessed the abuse, d. She stated, "No." She was divinessed the abuse were porting timely. She stated, deep none, the DON was asked if the don 02/22/21 around 2:00 s." She was asked if LPN #3 there. She stated, "Yes." She continued to work with the resident protected. She did be, because we didn't know sked, since the staff failed to the diately, were the residents d, "No."  If the resident was assessed the stated, "No."  Who witnessed the abuse did that it. As a result, LPN #3 the and other residents for four and 48 minutes.  Let any corrective measures in the from reoccurring. As a messes [CMA #4] had an abusing a different resident. ated allegation and while LPN #3 continued to be | F 6                 |  |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---|-----|---|-------------------------------|----------------------------|
|   |  | 375488   | B. WING                                 |     |   | l                             | C                          |
| NAME OF PR  | ROVIDER OR SUPPLIER  | 3/3400   | B. WING                                 | 301 | REET ADDRESS, CITY, STATE, ZIP CODE  I SOUTH OAKWOOD ROAD  IID, OK 73706  | <u>  07/</u>                  | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG  |  |  | ID<br>PREFIX<br>TAG                     | (   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 610   | Continued From page  | 94   | F 6                                     | 310 |   |                               |                            |
|   | _  | omplete a through and<br>n into the allegation of verbal   |   |     |   |                               |                            |
|   | 3. Resident #5 was a diagnoses which inclu   | dmitted to the facility with uded dementia.  |   |     |   |                               |                            |
|   | documented the resid   | essessment, dated 05/02/21,<br>dent's cognitive skills for<br>was severely impaired.   |   |     |   |                               |                            |
|   |  | .Description of  |   |     |   |                               |                            |
|   | towards a resident by member suspended p   | staff member. Staff<br>pending investigation"  |   |     |   |                               |                            |
|   | #2] asked me if I coul yes just give me a se middle of taking care I walked into [residen ahold [sic] of his Righ on him while she was bare skin I yelled at way [and] she was lik | om CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had at arm yanking [and] pulling s slapping at his left leg,-on ther to stop doing him that te what [and] just kind of the bed, she went to pull on   |   |     |   |                               |                            |
|   | his arm to get him up<br>would take care of hir<br>breakfast [and] told the<br>just happened. When<br>#2] she told her to sta<br>[resident #5]. When<br>[10:00 a.m.] I asked it    | I told her to just leave that I m. I brought him out for the Charge Nursewhat had the [LPN #2] talked to [CNA the ay away from direct care of the seen [sic] D.O.Naround the full [LPN #2] had talk to her the bed, sie with the build of the bed, sie with the build of the bui |   |     |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G | , ,   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--------------------------|---------------------|---|-------------------------------|----------------------------|
| 375488  |  | B. WING _                |                     | 07/01/2021  |                               |                            |
|   | NAME OF PROVIDER OR SUPPLIER  THE COMMONS  |                          |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706           |                               | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 610   | A written statement documented, "[CM. yelled at [CNA #2] me to help get him room where she wather states she sath his left leg so I to finish him, I went to happened she said never hurt anyone room"  A written statement documented, "[redesided [sic] to get then uncovered him was getting him dren his pull-up on the [safter that I took his ready to put his arrwent to put his head me. got his head in shirt down. tried to on leg to Push Leg have my other hanhim sit up. then ho stand him to finish was fighting me. I [sic] him down to re [CMA #2] came in thold him up. then the sic] she would abusing him. I Left room. then the nur her no i was patting | are but now she is [and] | F 6                 | 10  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTII<br>A. BUILDIN  | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   | 375488   | B. WING             |  |                               | C<br>07/01/2021            |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                        |                               | 3770 11202 1               |
| (X4) ID<br>PREFIX<br>TAG  |   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 610   | "Who isthe report #2]Who isreporte #2]What happene yanking on Residen legWhat was done from further harm around the resident nurse on the hall an sent home pending DONWhat is the hall the incident foresee of being combative deliveredWhen die happen06/07/21, supervisory/manage about the incident  A final state report, "A skin sweep was by two nurses with a Accused perpetrato 06/07/2021 pending 06/08/2021 she was the Administrator. Sor what could be coalso completed a Reunderstanding Demperpetrator was allo 06/08/2021"  CNA #2's time sheet documented she was a.m. to 10:04 a.m., since was done was allowed | nmary, undated, documented, rted victim[resident ed perpetrator[CNA dAllegation that CNA was ts arm and slapping his e to protect the resident(s) Staff member was told not go until further notice by the d then was suspended and investigation by the distory of the resident Was ableResident has a history to staff when cares are d the incident (7:30 a.m.]When was facility ement staff first contacted [10:00 a.m.]"  dated 06/08/21, documented, as completed on the resident ro injuries notedThe result was suspended on an investigation. On a counseled by the DON and the received verbal education insidered to be abuse. She call as Training entitled the intia. The accused wed to return to work on the tolerance of the county of the cou | F 6                 |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | IPLE CONSTRUCTION  NG |  | (X3) DATE SURVEY COMPLETED      |                        |  |  |
|---|--|--|-----------------------|--|---------------------------------|------------------------|--|--|
|   |  | 375488   | B. WING _             |  |                                 | C<br><b>07/01/2021</b> |  |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706  |                                 |                        |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF<br>( (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIA | DATE                   |  |  |
| F 610   | unsubstantiated ever witness, and failed to investigation by intervand residents.  On 06/24/21 at 12:48 to describe her invess she would complete and suspend staff, ta staff on the hall that to complete safe survey the section of the hall was asked if staff worstated not always. So considered interviewi on other halls. She so other staff but not oth asked when the investigation stated at en 06/07/21 at when the investigation stated, "I feel it was to the resident was asked when the resident was asked when the investigation stated, "I feel it was to the resident was asked when 06/07/21. She stated land when she is uspended and sent she worked on 06/08 here at 8:30 a.m. to received. She stated about dementia, she | mented the allegation was a through there was a complete a thorough viewing other staff members  In p.m., the DON was asked tigation process. She stated an incident report, remove ke statements from other the incident occurred and its on cognitive residents on the incident occurred. She read the same hall. She the was asked if she ing other staff and residents stated she has interviewed the residents. She was stigation was started. She in was completed. She in was completed. She in was conducted. She in was asked if it is stated, "No."  In CNA #2 had worked on it is she left at 10:04 a.m. for returned, she was shome. She was asked when in was asked was asked was asked was asked was asked was asked when in was asked w | F6                    | 510  |                                 |                        |  |  |
|   |  | ours on the 8th. The DON ective actions were put in  |                       |  |                                 |                        |  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '  | PLE CONSTRUCTION  G | COMPLETED   |                   |
|---|--|--|---------------------|---|-------------------|
|   |  | 375488   | B. WING             |   | 07/01/2021        |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             | 1 0//01/2021      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION |
| F 610   | place to prevent furth residents. She state The DON stated she happened because (and she called the Cacknowledged staff of the incident in a time.  LPN #2 did not report immediately and as a work with other reside and a half to two and investigation was no interviewing other state it is unknown if other involved.  4. Resident #8 had a pressure ulcer to the vacuum (vac) and part of the vacuu | ner abuse and protect the d there were no changes. didn't feel the allegation CNA #2 left the door open MA for help. She did not notify DON or ADM of a result, CNA #2 continued to ents for approximately one if a half hours. A thorough the completed by not aff and residents. As a result, residents had been diagnoses which included sacrum requiring a wound win.  #2, dated 06/27/21, reked from 5:33 p.m. to 5:39  A #5, dated 06/27/21, reked from 10:01 p.m. to 5:39  ed 06/28/21 at 4:23 a.m., than [sic] began saying that | F 6                 |   |                   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                    |     | (X3) DATE SURVEY<br>COMPLETED  |                 |                            |
|--|--|---|--------------------|-----|--|-----------------|----------------------------|
|  |  | 375488  | B. WING            |     |  | C<br>07/01/2021 |                            |
| NAME OF P  | ROVIDER OR SUPPLIER  | 0.0.00  |                    | 3   | STREET ADDRESS, CITY, STATE, ZIP CODE SO1 SOUTH OAKWOOD ROAD ENID, OK 73706                                  | 1 077           | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG   |  |   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                 | (X5)<br>COMPLETION<br>DATE |
| F 610  | They were asked who call. One stated, "Ab At 5:25 a.m., the adm talk to you guys." Sh lady who says she was the two ladies home."  An OSDH incident redocumented, "Final of Abuse/Mistreatmer IncidentResident mbeing raped by 50 pewas also saying we when staff CMA gave [signs/symptoms] of pay and final reports, of the investigation | and been sexually abused. In they had received the out five minutes ago."  Ininistrator stated, "I need to be stated, "We have a crazy as raped and I didn't send are port, dated of 06/27/21,[Resident #8]Allegations and and see allegation that she was ople every 30 minutes. She are trying to poison her are ultramNo S/S obysical rape notedFor 5 please include a summary see attached  Inter and time of report at 5:10 p.m., documented, orted perpetrator(s)A mWhat on of Rape and bed be to protect the resident(s) attaff was to always go in and the second and the second at the second and | F                  | 610 |  |                 |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | PLE CONSTRUCTION  G | COMPLETED   |                    |  |
|---|--|---|---------------------|---|--------------------|--|
|   |  | 375488  | B. WING             |   | C<br>07/01/2021    |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             | 1 07/01/2021       |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETION |  |
| F 610   | sign of bugs. She the she was raped. She allegations. She said woman and there is a She cannot really de going in her room with being told by Administ in with 2 Licensed nut. A statement from CN 12:32 p.m., documer #8] started yellingS yelling rape. She said everyone has been rependent every 30 and A statement, dated 0 documented, "Reside abused and raped resident #8's room in Rape multiple times a coming"  On 06/28/21 at 6:27 had received a text in nurse last night at 11 resident's wound vac was observed to be in from the charge nurse when the nurse went resident alleged raped the nurse had inform to go in there alone. told the nurse to go a get a description of was get a descript | an [sic] began saying that has been yelling these d that the rapest [sic] is a 50 of them every 5 minutes. Scribe themStaff has been th 2 people and then after stration we have been going urses"  A #5, dated 06/28/21 at atted, "At 11:14 pm [Resident shortly after she started id she was raped and that aped. She said that she has minutes by 50 people"  6/28/21, from CNA #7, ent stated she was being | F 61                |   |                    |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTII<br>A. BUILDIN  | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY COMPLETED |                            |
|--|---|--|---------------------|--|----------------------------|----------------------------|
|  |   | 375488   | B. WING             |  | 07/01/2021                 |                            |
| NAME OF PI   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                        |                            | 7770172021                 |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 610  | The charge nurse to "looks like us."  The ADM was aske with the resident lass she stated she had the family and phys resident. She state assessed. The administer, "You can't raclose to." She was that had been work stated it was a CNAThe ADM was aske residents once she allegation of rape. with two, always two facility policy was for was an allegation of find the policy." Shireading it. She stat them, suspend." SI | D people every 30 minutes. Dold the ADM that the rapist  Indicate the house to inform the people and to assess the difference to the ministrator stated she told the pe someone you can't get asked who the two staff wereing with the resident. She | F 6                 | 10   |                            |                            |
|  | at the time." She st<br>She was asked wha<br>She stated, "I don't<br>She was asked if he<br>employees for alleg<br>followed. She state<br>On 06/29/21 at 11:3<br>regarding resident #<br>reviewed with the A<br>her report on the sta   | ated, "I came and did it later." at time she suspended them. know, I was with the police." er policy for suspending ations of abuse had been d, "No."  0 a.m., the investigation the allegation of rape was DM. She stated she based                 |                     |  |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|---------------------|--|-------------------------------|----------------------------|
|   |  | 375488  | B. WING             |  |                               | C<br>07/01/2021            |
| NAME OF PI  | ROVIDER OR SUPPLIER  | 1 0.0.00  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | ı                             | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| F 610   | perpetrators as "lool investigative report of unable to give a des "Yes", referring to the information. She we concerned about the "What does the report of interview from yestereported to her the of "looks like us" and the resident was unabled. There was no respoon to two employees facility all night after resident identifying the who raped her.  The facility failed to investigation into the facility failed to investigation into the facility all night after resident identifying the facility failed to investigation into the facil | esident described the as like us" and that the documented the resident was cription. The ADM stated, e discrepancies in as asked if she was a discrepancies. She stated, art say." Reviewed her reday that she stated the nurse escription the resident stated he report documented the to describe the perpetrator. In the allegation of rape and the her RN and CNA as the ones allegations.  It dated 02/15/21, dent's cognition was intact.  103/21/21, documented LPN a.m., to 3:21 p.m.  10 03/21/21 at 1:44 p.m., ent observed on floor lying on dent report, dated 03/21/21, gations of Abuse | F 6                 | 10   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '  | LE CONSTRUCTION     | (X3  | (X3) DATE SURVEY COMPLETED |                            |
|---|---|--|---------------------|--|----------------------------|----------------------------|
|   |   | 375488   | B. WING             |  |                            | C<br><b>07/01/2021</b>     |
| NAME OF P   | ROVIDER OR SUPPLIER   | 0.0.00   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | ı                          | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |
| F 610   | director that activity a statement, that she o F****** Christ, [Residnotified he had fallen The nurse is suspend complete" A facsin documented the repoletic documented the repoletic documented the repoletic documented the resident.  There was no documed clinical record of the aresident.  The facility did not repoletic documented two documented docu | wide reported to her in a verheard a nurse say "Jesus ent #6] really? when she was . Nurse is not on shift today. Ided until investigation is hile (fax) cover sheet, but was sent to the OSDH on  entation in the resident's calleged abuse against the  port the allegation of abuse the Department of Health for hours.  If #1 documented she from 5:42 a.m. to 2:34 p.m.  faxed to OSDH on 03/23/21 anted the followingFor 5 please include a summary Face Sheet attached, d"  Inducted with three residents dowing questions were then you turn on your call aing you need taken care of? aff using inappropriate are do reposed aren't met, do you | F 61                |  |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | 1 ' '  |   | (X3) DATE SURVEY COMPLETED   |  |  |
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|  | 375488   | B. WING  |   | C<br>07/01/2021  |  |  |
| ROVIDER OR SUPPLIER  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706   | 1 07/01/2021   |  |  |
| (EACH DEFICIENC  | CY MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)  | JLD BE COMPLETION  |  |  |
| verbal abuse had be investigation.  There were no writte reporting staff membor other staff with the administrator docum the staff member ma others. She documented reported hearing the member who had ma administrator docum incident did not occur.  On 06/24/21 at 1:35 when LPN #1 worked she worked til 3:21 p did the LPN receive. She was asked where completed. She state completed, but the distated there was compand LPN #1. She was worked during the instated, "Yes." She was place to prevent recorresidents. She state She was asked, how protected if the LPN investigation. She stre-interviewed and his the allegation could in asked if was reported not notified until the incomposition. | en made and throughout the  In staff statements from the er, the perpetrator (LPN #1) e investigation. The ented that she had spoken to king the allegation and three ented she spoke with resident d the only person who comments was the staff ade the allegation. The ented her conclusion was the r.  In the DON was asked d on 03/21/21. She stated I.m. What disciplinary action The DON stated, "None." In the investigation had been ed the investigation was ocumentation was not. She efflict between the activity aide as asked if LPN #1 had vestigation. The DON vas asked what was put in courrence and to protect the d there were no changes. I residents had been worked during the stated the complainant was and a discussion about how not have occurred. She was d timely. She stated she was next day.  a.m., the activity aide was  | F 6  |   |  |  |  |
|  |  |  |   |  |  |  |
|  | ROVIDER OR SUPPLIER  MONS  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag verbal abuse had be investigation.  There were no writte reporting staff membor other staff with the administrator documenter reported hearing the member who had man administrator documented reported hearing the member who had man administrator documented reported hearing the member who had man administrator documented reported hearing the member who had man administrator documented for the LPN #1 worked she worked til 3:21 periodic did not occur. On 06/24/21 at 1:35 when LPN #1 worked she worked til 3:21 periodic did the LPN receive. She was asked when completed. She state completed, but the distance to prevent recording the instance of the LPN investigation. She state she was asked, how protected if the LPN investigation. She state she was asked, how protected if the LPN investigation could in asked if was reported not notified until the investigation could in asked if was reported not notified until the investigation could in asked if she recalled asked if she recalled the country of the province of the country of the province of the country of the count | TIDENTIFICATION NUMBER:  375488  ROVIDER OR SUPPLIER  MONS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 104  verbal abuse had been made and throughout the | ROVIDER OR SUPPLIER  MONS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 104  verbal abuse had been made and throughout the investigation.  There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.  On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation was completed. She stated the investigation was completed. She stated the investigation was completed. She was asked what was put in place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.  On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. | ROVIDER OR SUPPLIER  MONS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESULATORY OR I.S. DENTIFYING INFORMATION)  Continued From page 104  verbal abuse had been made and throughout the investigation. The perpetrator (LPN #1) or other staff with the investigation. The administrator documented her conclusion was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.  On 06/24/21 at 1:35 p.m., the DON stated, "None." She was asked when the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked when the investigation had been completed, but the document and to protect the residents. She stated the complainant was re-interviewed and had a discussion about how the allegation. She stated the exit protected if the LPN worked during the investigation. The DON stated, "Yes." She was asked, how residents had been protected if the LPN worked during the investigation. The pontage is the protected if the LPN worked during the investigation and the place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. The DON stated, "Yes." She was asked whan the investigation the protection of the LPN worked during the investigation. The DON stated is the LPN worked during the investigation. The DON stated is the LPN worked during the investigation and the protected if the LPN worked during the investigation and the protected if the LPN worked during the investigation and the protected if the LPN worked during the investigation and the protected if the LPN worked during the investigation and the protected if the LPN worked during the investigation and the protected if the LPN worked during the investigation and the protected if the LPN worked during the investigation and the protected if the LPN worked during the investigation i |  |  |

| AND DI AN OF CORRECTION IDENTIFICATION NUMBER |   | 1 ' '   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|---------------------|--|-------------------------------|----------------------------|
|   |   | 375488  | B. WING_            |  |                               | C                          |
| NAME OF P                                     | ROVIDER OR SUPPLIER   | 0,040   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | l                             | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| F 610   | cursed at the reside that he had fallen. S "Jesus F*** Christ, [ asked who she had stated she reported and that her superviadministrator.  The facility failed to investigation of abuse allegation of abuse allegation to the adragencies timely.  6. Resident #1 was diagnoses which incompaired.  A quarterly resident documented the resimpaired.  A state incident reported documented, "Resimpaired.  A state incident Type Abuse/Mistreatmented the resimpaired.  A notification of nursing 106/12/21, documented the remoleyee terminate 6/12/2021ALLEG/ABUSEOn June 1 11:00 am a incident member in which a involved. CNA #1 resident for her and she personal SnapChat does your resident for reason??" The cap | In twhen she reported to her She stated, LPN #1 said, Resident]. Really." She was reported the incident to. She it to her supervisor that day isor was going to call the protect residents during an se, thoroughly investigate an and failed to report the ministrator and appropriate admitted to the facility with cluded Parkinson's disease.  assessment, dated 06/12/21, sident's cognition was severely out form, dated 06/12/21, sidentInvolved[resident]  as aide report, dated ted, "CNA #1was dYestermination date | F6                  | 10   |                               |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  | (>                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|--------------------------------------|-------------------------------|--|
|                          |  | 375488  | B. WING             |  |                                      | C<br><b>07/01/2021</b>        |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIF 301 SOUTH OAKWOOD ROAD ENID, OK 73706 | CODE                                 | 07/01/2021                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE       | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 610                    | was terminated for m violation of our facility On 06/23/21 at 8:59 a when the staff were in phone use and social in serviced when they She was asked what media restrictions we anything about reside pictures. She stated cell phones in break rephone in resident are the staff were in service She stated they plant July. She stated they plant July. She stated they had to wait for the updated policy. She measures were put in | istreatment of a resident and a Social Media Policy"  a.m., the DON was asked a serviced related to cell media. She stated they are a re hired during orientation. The cell phone and social re. She stated not to post ents, the facility and no staff were only to have their room and not to have a cell as. The DON was asked if ced related to the incident. The don in servicing staff in a were going to in June but their board's approval of the was asked if any corrective | F                   | 510  |                                      |                               |  |
| F 684<br>SS=E            | what staff were intervinvestigation. She stathey did not interview working that same sh staff members were rethorough investigation "Guess not." She was protected from further they did not initiate and A thorough investigat related to this incident if any other staff or requality of Care   | ift. She was asked if other not interviewed, was a nocompleted. She stated, is asked how residents were roccurrence. She stated   | F                   | 684  |                                      |                               |  |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '              |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|--------------------|-----|--|-------------------------------|----------------------------|
|                          |   | 375488   | B. WING            |     |  |                               | C<br>01/2021               |
| NAME OF PE               | ROVIDER OR SUPPLIER   |  | -                  | 3   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>801 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                            |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 684                    | applies to all treatme facility residents. Bas assessment of a resithat residents receive accordance with prof practice, the comprel care plan, and the rethis REQUIREMENT by:  Based on record revivas determined the fiphysician's orders we three sampled reside physician's orders.  The facility identified facility.  Findings:  Resident #3 had diag fractured left humeru | are Indamental principle that Int and care provided to sed on the comprehensive dent, the facility must ensure the treatment and care in dessional standards of mensive person-centered sidents' choices. If is not met as evidenced diew and staff interview, it facility failed to ensure there followed for one (#3) of mension that is reviewed in the  195 residents resided in the  196 gnoses which included 198 s.  198 criment final report, dated 199 dated 19 | F                  | 684 | ,  |                               |                            |
|                          | Within 1-2 days"  A progress note, date documented the residuith no new orders.  A progress note, date documented a virtual physician had been of   | ed 02/05/21 at 9:54 p.m., dent returned to the facility ed 02/12/21 at 9:14 a.m., visit with the resident's conducted. This was the first ency department visit.   |                    |     |  |                               |                            |

|                          | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |              |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
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|                          |  | 275400   |              | _   |  |                               | C                          |
| NAME OF D                | DOVIDED OD CLIDDLIED   | 375488   | B. WING      |     | TREET ADDRESS CITY STATE 7ID CORE  | 07/                           | 01/2021                    |
| NAME OF PE               | ROVIDER OR SUPPLIER  |  |              |     | TREET ADDRESS, CITY, STATE, ZIP CODE  01 SOUTH OAKWOOD ROAD                          |                               |                            |
| THE COM                  | MONS   |  |              |     | NID, OK 73706  |                               |                            |
| ()(1) ID                 | STIMMADA ST  | ATEMENT OF DEFICIENCIES  | ID           |     | PROVIDER'S PLAN OF CORRECTION  |                               | (VE)                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFI<br>TAG | X   | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 684                    | Continued From page  | : 108  | F            | 684 |  |                               |                            |
|                          | was shown the emergreport and the progre<br>She was asked if phy   | o.m., the director of nursing<br>gency department final<br>ss note of the virtual visit.<br>sician's orders had been<br>r-up appointment. She<br>fically."   |              |     |  |                               |                            |
| F 835<br>SS=K            | Administration<br>CFR(s): 483.70   |  | F            | 835 |  |                               |                            |
|                          | enables it to use its re efficiently to attain or practicable physical, it well-being of each rest This REQUIREMENT by:  On 06/28/21, an Immistration was determifiated to have an effect implement an abuse part of the complex of the | ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  is not met as evidenced nediate Jeopardy (IJ) ned to exist related to facility etive administration to |              |     |  |                               |                            |
|                          | reprisal.  A staff member allege refusing/withholding p#9. The allegation wa administrator and a tr not conducted. The e   | ed that LPN #3 had been pain medications to resident as not reported timely to the morough investigation was amployee remained working on and no action was taekn  |              |     |  |                               |                            |

| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835  Continued From page 109 against the nurse.  An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work.  The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further   | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN  | PLE CONSTRUCTION  IG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|--|----------------------|---|-------------------------------|----------------------------|
| THE COMMONS  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (XA) ID PREFIX TAG  Continued From page 109 against the nurse.  An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work.  The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further  STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION OCCUMPLE TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION (CX) PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (CX) PROVIDER'S PLAN OF CORRECTION (CX) PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (CX) PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (CX) PROVIDER'S PLAN OF CORRECTION (CX |   |  | 375488   | B. WING _            |   |                               |                            |
| F 835  Continued From page 109 against the nurse.  An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work.  The facility documented an incident of resident #5 being physically abused by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further   |   |  |  |                      | 301 SOUTH OAKWOOD ROAD                            | •                             | 0770172021                 |
| against the nurse.  An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work.  The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further  | PRÉFIX  | (EACH DEFICIEN   | ICY MUST BE PRECEDED BY FULL   | PREFIX               | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.  Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigation was on going.  At 3:03 p.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.  At 3:30 p.m., the Administrator (ADM) was notified of the IJ.  An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:   | F 835   | against the nurse.  An allegation of star resident #7 on 02/2 02/23/21, one day a The residents were member was allowed.  The facility docume being physically about reported by staff. To resident, complete a implement corrected abuse.  Resident #8 made at on 06/28/21 and the continue to work over allegation was made.  Staff witnessed vertain employee and residents were not perpetrator remaining work while the investigation residents were not perpetrator remaining work while the investigation of the IJ states of the IJ states and provided by the administration of the IJ.  An acceptable, ame provided by the administration of the IJ. | If being verbally abusive to 2/21 was not reported until after the allegation occurred. not protected as the staffed to work.  Inted an incident of resident #5 used by staff witnessed and the facility failed to protect the athorough investigation and domeasures to prevent further an allegation of rape by staffed staff had been allowed to be er six hours after the endance of the end at work and conducted. The protected due to the end at work and continued to estigation was on going.  In allegation of removal was ended plan of removal was ended plan of removal was ended plan of removal was ninistrator on 06/29/21 at 7:20 | F8                   | 35  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  IG |  | (X3) DATE SURVEY<br>COMPLETED |                            |
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|   |  | 375488   | B. WING _            |  |                               | C<br>07/01/2021            |
| NAME OF P   | ROVIDER OR SUPPLIER  | 1  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706      | •                             | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 835   | the INCIDENT RESI and includes the Adrian includes the Adrian Administrator, DON, Center Resident ser administrator or des of Director any alleg scheduled monthly r INCIDENT response an outside source or including screening, Investigating, protect on 06/30/2021 with a To always protect ouresponse team will respond to allegation investigation has be On 07/01/21, the adinterviewed and wer components of abuse. The immediate jeops of 06/30/21 at 5:10 pplan of removal and had been implement remained at a level of Based on observation interview it was determined at a level of the additional transfer in the immediate interview it was determined at a level of the additional transfer in the immediate in the immediate in the implementation of the immediate in the immedia | TE team was formed called PONSE TEAM on June 29th, ministrator, Assistant ADON, and HealthCare vices Director. The ignee will report to the Board ation of abuse at regularly meetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ting, and reporting/response advanced training on ABUSE. It residents, the INCIDENT meet to collaborate and the sto ensure a thorough en completed. | F8                   | 35   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                    |     | (X3) DATE SURVEY<br>COMPLETED  |     |                            |
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|  |   | 275400   | B. WING            |     |  | 1   | 0                          |
|  | 20/4252 02 04/224/52  | 375488   | B. WING            | _   |  | 07/ | 01/2021                    |
| NAME OF PI   | ROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |     |                            |
| THE COM  | MONS  |  |                    |     | SOUTH OAKWOOD ROAD   |     |                            |
|  |   |  |                    |     | ENID, OK 73706   |     |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |     | (X5)<br>COMPLETION<br>DATE |
| F 835  | (#1, 5, 6, 7, 8 and #9) reviewed for abuse; a ~ have an environent allegations of abuse/reprisal.  The facility Censeus Findings:  1. Resident #9 had a chronic pain and oster documented the residence and commented the residence and environmented the residence and environmented in a trisk muscle spasms and a syndromeResident treated/relieved in a t | vere free from abuse for six of six sampled residents and the sampled residents and the sampled residents and the sampled residents and the sampled residents are sampled residents and the sample r | F                  | 835 |  |     |                            |
|  | route every 6 hours a  A statement from CM  |  |                    |     |  |     |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                | TIPLE CONSTRUCTION NG  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|--------------------|--|-----------------------------------|-------------------------------|--|
|                          |   | 375488  | B. WING            |  |                                   | C<br>7/01/2021                |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZIP 301 SOUTH OAKWOOD ROAD ENID, OK 73706         |                                   | 770 1/2021                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF<br>X (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 835                    | thing in the mornin [Resident #9] get to ask for a pain pill. Norco and rate his butt pain. As protorequest to the chargo to the resident report back to me, administer a pain to level of the pain the location of the pain the location of the pain meds doesn't need a pain smoke a cigarette, he can go outside pain pill because he can go outside pain pill because he can go outside pain pill because he can go outside pain meds until so p.m. as reflected to administration reconstruction | ons, typically beginning first ag after the CNA has helped up out of bed for the day, he will He will specifically ask for a pain at an 8 out of 10 for leg or ocol, as the CMA, I report the rege nurse, the charge nurse will to evaluate the resident and the CMA, with guidance to med and instruct me with the at was reported and the pain. On many occurrences, the resident, [Resident's stating 'He just got up, he in pill' or 'He's going outside to he's not hurting bad enough if to smoke' or 'He can't have a me hasn't eaten anything yet.' ees, [Resident] won't receive metimes 10 a.m or as late a 2 in the MAR [medication] | F                  | 335  |                                   |                               |  |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDII | PLE CONSTRUCTION  G                                   |   | (X3) DATE SURVEY<br>COMPLETED |      |
|--------------------------|--|---|-------------------------|---|---|-------------------------------|------|
|                          |  | 375488  | B. WING _               |   |   | C<br><b>07/01/2021</b>        |      |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   |                         | STREET ADDRESS, CITY 301 SOUTH OAKWOOD ENID, OK 73706 |   | 0770172021                    |      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | (EACH COF   | ER'S PLAN OF CORRECTION<br>RRECTIVE ACTION SHOULD BE<br>ERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | TION |
| F 835                    | Continued From pag   |   | F 8                     | 35  |   |                               |      |
|                          | related to receiving   | d to the residents were not<br>pain medications.  |                         |   |   |                               |      |
|                          |  | nted the allegation was<br>completed on 06/27/21 at   |                         |   |   |                               |      |
|                          | The employee continuous investigation of the a   | nued to work during the lleged negelct.   |                         |   |   |                               |      |
|                          | The facility did not convestigation and intinclude the alleged with medications being with the facility of the | erview residents and staff to<br>rictim regarding pain  |                         |   |   |                               |      |
|                          | assistant administra<br>conclusion of the invadministrator stated<br>spreadsheet of which<br>versus the Norco. Shad administered the<br>other nurses. She was documentation of the<br>requested the Norco<br>you could tell when asked if there was no<br>resident requested if withheld the medica<br>conclusion the alleg.<br>She stated she went  | O p.m., the administrator and tor were asked about the vestigation. The assistant she had made an excel h nurse had given Tylenol she stated the accused nurse e medications as much as the vas asked if there was e times the resident had b. She stated she didn't think the had requested it. She was to documentation of when the thank and the CMA stated LPN #3 tion, how did they come to the ation was unsubstantiated. It to the resident and asked atted the resident is this erleader. |                         |   |   |                               |      |
|                          | There were no ques related to staff withh stated the executive   | M provided resident surveys. tions asked to the residents olding pain medications. She director had made the that the question "Do staff  |                         |   |   |                               |      |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | I ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---|---|-------------------------------|----------------------------|
|  |  | 375488  | B. WING _                               |   |                               | C<br>07/01/2021            |
| NAME OF PI   | ROVIDER OR SUPPLIER  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                     |                               | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF COR<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 835  | make decisions regathat.  On 06/29/21 at 6:35 if he was in pain. Hright side, leg and krate it at an 8 out of a 9 in the mornings. he did not get his Not stated, "If I don't was asked if his Not stated it was and the disclose who the emmedication.  At 7:02 p.m., CMA # allegations made re Norco. She stated, the time." She stated because when he approtocol I have to fo would give the same in her statement. Sitake their pain as the #3 would have her approximately disorder.  A quarterly resident documented the resimpaired.  A state incident reports | p.m., the resident was asked e stated he had pain in his nee. She stated he would 10. He stated it was usually He was asked how he felt if procowhen he requested it. get them, I get mad." He cowas ever withheld. He en stated he would not aployee was that witheld the garding LPN #3 withholding "Norco is what he asks for all ed, "It's upsetting to me sks for something, I have llow." She stated that LPN #3 e responses CMA #3 had put ne stated she was taught to eay stated it. She stated LPN administer Tylenol or Ultram of the stated to the facility with eluded convulsions and assessment, dated 02/18/21, ident's cognition was severely out form, dated 02/23/21, | F8                                      |   |                               |                            |
|  | documented, "Inci<br>Abuse/Mistreatment  | dent TypeAllegations of<br>Description of   |   |   |                               |                            |

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | l ` ′              |     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|--------------------|-----|---|-------------------------------|----------------------------|
|                          |   | 375488   | B. WING            |     |   | · ·                           | 04/0004                    |
| NAME OF PI               | ROVIDER OR SUPPLIER   | 0.0400   |                    | 3   | OTREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH OAKWOOD ROAD  ENID, OK 73706                                 | <u> </u>                      | 01/2021                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 835                    | allegation of verbal at from a staff member a is not on the schedule not be working until the investigated. Investig day and final reports, of the investigationa implemented to preveattached for investigatesident. She was su ways to recognize but the employee Assistance. The allegation of abut administrator until the administrator until the the employee Assistance. The facility failed to rewithin two hours to the asthe Oklahoma State (OSDH).  A written statement by documented, "The daspent a majority of the hallway outside of [ar approximately 2 p.m. himself in his wheeled station area and park outside of the wound Immediately the chargand yelled to [residen here, you're not going here." [Resident #7] yelled at [LPN #3]. It is at her, his speech is controlled to the hell outside of the hell outside in get the hell outside in get the hell outside in th | or was notified today of an ouse occurring on 02/22/21 against a nurse. The nurse e until Thursday. She will ne allegation has been gation is in progressFor 5 please include a summary and corrective measures ent recurrenceSee tion: Nurse yelled at aspended and counseled on remout. Also gave her information"  see was not reported to the enext day after it occurred.  Report the allegation of abuse e appropriate agencies such the Department of Health  by CMA #3, dated 02/23/21, by of 2-22-21, [resident #7] are day sitting in the North Hall nother resident]s room. At a [resident #7] wheeled the process of the nurse's end himself in his wheelchair | F                  | 835 |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | E CONSTRUCTION      | (X3) DATE SURVEY COMPLETED  |                 |  |
|---|--|---|---------------------|---|-----------------|--|
|   |  | 375488  | B. WING             |   | C<br>07/01/2021 |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                                     | 1 07/01/2021    |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE)   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETION |  |
| F 835   | nurse's station area his roomDuring the sitting in a chair been tire event"  A written statement documented, "On Matage and the statement of the evening"  A written statement of the evening"  A written statement of the evening"  A written statement of the evening of the evening of the evening of the getting something wat [resident #7]. Ar [Resident #7] starter #3] got louder and statement of the evening of the evening of the evening of the evening of the getting something wat [resident #7] starter #3] got louder and statement of the statement of | ge 116 ed himself away from the a back down the hall towards his occurrence, [CMA #4] was side me and witnessed the  by CMA #4, dated 02/24/21, Monday February 22nd I [CMA I was on North Hall. I was tion [resident #7] the resident to the Common Area by the I #3] the nurse told him to turn of the said he has rights She not gonna [sic] deal with you need to sit up here She and said "I dont give a dam [sic] up here Im not gonna [sic] so [resident #7] sat in the left he was very upset the rest by CNA #3, dated 02/24/21, other day I was in the office when I heard [LPN #3] yelling and telling him to go to his room. Ed yelling back at her and [LPN told him she wasn't going to bour room. [LPN #3] then said | F 83                |   |                 |  |
|   | Im sick of him action  A written statement 5:00 p.m., documer [administrator (adm back [and] was told against me for yelling Monday February 2 [approximately] [2:0 the man but suppose  | g like this"  by LPN #3, dated 02/24/21 at nted, "Missed a call from in)] [at] the Commons. Called there was an allegation ng [at] a male on North Hall on  |                     |   |                 |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | A. BUILDIN  | PLE CONSTRUCTION  G | , ,   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---------------------|---|-------------------------------|----------------------------|
|  |  | 375488  | B. WING _           |   |                               | C<br><b>07/01/2021</b>     |
| NAME OF P  | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                       | '                             |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 835  | hall or go to his root to sit in the area by it congests the hall towards the resident "Who is/are the reformWho is/are the #3]Who witnessed [CNA #3], [CMA #4] happenedResider sitting near the nurse came down the hall leave the deskWhresident(s)? Was thresident(s)? Was thresident has had our eason a staff member sho this incident was no victim want to happe discuss the incident would like to happe shoulderWhen did 2pm on Feb [Februs supervisory/managa about the incident  An Oklahoma Board submitted date 02/2 Name: [LPN #3]D or Criminal Behavior abuseDescription suspended pending returned to work on disciplinary action were submitted to work on the submitted disciplinary action were submitted to work on the submitted disciplinary action were submitted to work on the submitted disciplinary action were submitted to work on the submitted disciplinary action we | dent to go away, go down the m. I had asked residents not wound care Nurse's office as vayMay of raised my voice t"  mary, undated, documented, eported victim[resident reported perpetrator[LPN d the incident[CMA #3],What ntwas in his wheelchair re's desk. [LPN #3] the nurse and started yelling at him to lat is the history of the ne incident foreseeableThe attreaks lately, but there is NO ber should yell at a resident, but the foreseeableWhat does the en[resident #7] would not to the incident happenAround ary] 22ndWhen was facility ement staff first contacted On Feb 23rd"  In of Nursing complaint form, 16/21, documented, "Nurse's id incident include Misconduct orYes: Patient of InvestigationLPN was the investigation and 02/26/2021. She received or the process of the process of the received or the process of the process | F 8                 | 35  |                               |                            |
| TAG  | Continued From part told I told male resident or go to his root to sit in the area by it congests the hally towards the resident would like to happenedResident sitting near the nurse came down the hall leave the deskWhappenedResident has had our eason a staff member should like to happe shoulderWhen did 2pm on Feb [Februs supervisory/managrabout the incident  An Oklahoma Board submitted date 02/2 Name: [LPN #3]Dor Criminal Behavior abuseDescription suspended pending returned to work on disciplinary action ware sident and for contrary to recognize.  | ge 117  dent to go away, go down the m. I had asked residents not wound care Nurse's office as vayMay of raised my voice t"  mary, undated, documented, eported victim[resident reported perpetrator[LPN d the incident[CMA #3],What ntwas in his wheelchair se's desk. [LPN #3] the nurse and started yelling at him to sat is the history of the ne incident foreseeableThe attreaks lately, but there is NO ber should yell at a resident. uld Never yell at resident, but at foreseeableWhat does the en[resident #7] would not at the incident happenAround ary] 22ndWhen was facility ement staff first contacted On Feb 23rd"  d of Nursing complaint form, 16/21, documented, "Nurse's id incident include Misconduct of InvestigationLPN was the investigation and 02/26/2021. She received write up for raising her voice at conducting herself in a manner   | TAG                 | CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3   | (X3) DATE SURVEY COMPLETED |  |          |                            |
|--|--|---|----------------------------|--|----------|----------------------------|
|  |  | 375488  | B. WING                    |  |          | C                          |
| NAME OF P  | ROVIDER OR SUPPLIER  | 373400  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | I        | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | IOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 835  | Continued From pa  | ge 118  | F 83                       | 35   |          |                            |
|  | 02/27/21, document p.m. on 02/22/21. L4 hours and 48 minuments and 60 minu | r period from 02/14/21 to ted LPN #3 worked til 6:48 LPN #3 worked approximately utes after the abuse occurred.  protect residents from further restigation.  report the allegation timely to d a through investigation was  P.P.M., the admin was asked lent that happened on ent #7. She stated the earing and LPN #3 stated she ed she reviewed the cameras, in the witnesses and LPN #3 incident with the resident's ed when LPN #3 worked on ed she didn't know. She was dent was reported. She fied on the following day. She outcome of her investigation was substantiated that LPN #3 ine was suspended and had a asked if the facility had a zero She stated, "If I say yes, my "She was asked what was prevent this from happening She stated they didn't add than what was in place. She staff can report suspected ed, "Any authority." She was of thad witnessed the abuse, y. She stated, "No." She was o witnessed the abuse were porting timely. She stated, |                            |  |          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ` ′  | PLE CONSTRUCTION  G | COMPLETED   |                    |
|---|--|--|---------------------|---|--------------------|
|   |  | 375488   | B. WING_            |   | C<br>07/01/2021    |
| NAME OF PI  | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                             | 1 07/01/2021       |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETION |
| F 835   | verbal abuse happer p.m. She stated "Ye continued to work aff was asked if LPN #3 residents, how were stated," They couldn about it." She was a report the abuse improtected. She stated after the incident. Since the ADM was asked after the incident. Since the incident of the worked with the victing approximately four hor the facility did not pure place to prevent abure sult, one of the with allegation of verbally The facility substantiterminated CMA #4 wemployed by the facility substantiterminated CMA #4 wemployed by the facility allegation of verbally The facility substantiterminated CMA #4 wemployed by the facility substantiterminated CMA #4 wemployed by the facility substantiterminated CMA #4 wemployed by the facility documented the residually decision making An initial incident reports. | p.m., the DON was asked if led on 02/22/21 around 2:00 s." She was asked if LPN #3 fer. She stated, "Yes." She continued to work with the resident protected. She is because we didn't know sked, since the staff failed to nediately, were the residents id, "No."  If the resident was assessed the stated, "No."  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the facility with unded dementia.  If the resident was assessed the stated to the resident was assessed the stated to the reside | F 83                | 35  |                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | l ` ′   | LE CONSTRUCTION     | COMPLETED  |                 |
|---|--|---|---------------------|--|-----------------|
|   |  | 375488  | B. WING             |  | C<br>07/01/2021 |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706                            | 0770112021      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | O BE COMPLETION |
| F 835   | towards a resident be member suspended  A written statement 06/07/21, document #2] asked me if I coryes just give me a semiddle of taking care I walked into [reside ahold [sic] of his Rigon him while she was bare skin I yelled a way [and] she was lidropped him back on his arm to get him us would take care of his breakfast [and] told just happened. When #2] she told her to se [resident #5]. When [10:00 a.m.] I asked [and] I told [DON] when she was not away asked me to write out A written statement documented, "[CMA yelled at [CNA #2] be me to help get him [room where she was at his left leg so I told finish him, I went to happened she said." | Description of an allegation of abuse by staff member. Staff pending investigation"  from CMA #2, dated ed "Around [8:30 a.m.] [CNA culd come help her I told her econd because I was in the expectation of the cond because I was in the expectation of the conduction of the conduction of the conduction of the conduction of the bed, she went to pull on the charge Nursewhat had the conduction of the charge Nursewhat had the ch | F 83                | 5  |                 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY COMPLETED |                            |
|---|---|---|-----------------------|---|----------------------------|----------------------------|
|   |   | 375488  | B. WING _             |   |                            | C<br>07/01/2021            |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706               | •                          | 0170172021                 |
| (X4) ID<br>PREFIX<br>TAG  | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 835   | documented, "[res desided [sic] to get if then uncovered him was getting him dreshis pull-up on the [si after that I took his in ready to put his arm went to put his head me. got his head in shirt down. tried to son leg to Push Leg i have my other hand him sit up. then holl stand him to finish g was fighting me. I w [sic] him down to res [CMA #2] came in the hold him up. then to the [sic] she would gabusing him. I Left room. then the nursher no i was patting down. [LPN #2] told until told other wise.  An investigative sum "Who isthe reported "2]What happened yanking on Resident legWhat was done from further harm saround the resident nurse on the hall and sent home pending DONWhat is the hold the incident foreseed. | from CNA #2, dated 06/07/21, ident #5] was awake. So him up. got his clothes ready started talking to him while seed. I started by putting [sic] c] then i put his pants on. cospital gown off. got his shirt in. then put the arm in as I his shirt, I told him not to Bite the whole [sic] [and] pull his sit him up By Putting my arm n a sitting position while i around upper back to help ered [sic] at [CMA #2] to help etting dressed. Because he was patting hisleg to clam sure [sic] it was ok. then seir [sic] saw i was trying to old me Let him lay Back down get him. then said was the room and went the Break eask me if i hit him I told him to try come [sic] him a me not go around him again"  Inmary, undated, documented, and perpetrator[CNA dAllegation that CNA was the arm and slapping his to protect the resident(s) Staff member was told not go until further notice by the did then was suspended and | F                     | 335   |                            |                            |

| AND DIAN OF CORRECTION IDENTIFICATION NUMBER |  | 1 ` ′   | PLE CONSTRUCTION  3 | , ,  | (X3) DATE SURVEY COMPLETED |                            |
|--|--|---|---------------------|--|----------------------------|----------------------------|
|  |  | 375488  | B. WING             |  |                            | C<br>07/ <b>01/2021</b>    |
| NAME OF P                                    | ROVIDER OR SUPPLIER  | ı   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          |                            | 1770 17202 1               |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |
| F 835  | deliveredWhen did happen06/07/21, [supervisory/manage about the incident[A final state report, or "A skin sweep was by two nurses with n Accused perpetrator 06/07/2021 pending 06/08/2021 she was the Administrator. Sor what could be corralso completed a Re Understanding Demoperpetrator was allow 06/08/2021"  CNA #2's time sheet documented she wo a.m. to 10:04 a.m., a a.m. and on 06/08/2 and from 1:57 p.m. to The facility had docum unsubstantiated every witness, and failed to investigation by inter and residents.  On 06/24/21 at 12:48 to describe her invest she would complete and suspend staff, to staff on the hall that complete safe survest the section of the hall state of the section of the hall that complete safe survest the section of the hall | Ithe incident 7:30 a.m.]When was facility ment staff first contacted 10:00 a.m.]"  Idated 06/08/21, documented, completed on the resident o injuries notedThe was suspended on an investigation. On counseled by the DON and he received verbal education isidered to be abuse. She dias Training entitled entia. The accused wed to return to work on  1, dated 06/06/21 to 06/19/21, rked on 06/07/21 from 6:30 and from 10:36 a.m. to 11:37 1 from 8:27 a.m. to 1:27 p.m., o 2:32 p.m.  Immented the allegation was in through there was a o complete a thorough viewing other staff members  28 p.m., the DON was asked stigation process. She stated an incident report, remove ake statements from other the incident occurred and tys on cognitive residents on Il the incident occurred. She orked the same hall. She | F 83                | 35   |                            |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDII   | FIPLE CONSTRUCTION  NG | , ,  | (X3) DATE SURVEY<br>COMPLETED     |                            |
|--|--|---|------------------------|--|-----------------------------------|----------------------------|
|  |  | 375488  | B. WING _              |  |                                   | C<br>07/01/2021            |
| NAME OF P  | ROVIDER OR SUPPLIER  | 1   |                        | STREET ADDRESS, CITY, STATE, ZIP O<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706 | CODE                              | 0170172021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG    | *  | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 835  | on other halls. She other staff but not other staff but not other staff but not other stated on 06/07/21 awhen the investigatic stated late on 06/07/thorough investigatic stated, "I feel it was the resident was assed elayed injury. She She was asked when 06/07/21. She state lunch and when she suspended and sent she worked on 06/08 here at 8:30 a.m. to Relias training then I was asked what discreceived. She stated about dementia, she and two and a half hwas asked what complace to prevent furth residents. She stated and she called the Cacknowledged staff of the incident in a time. LPN #2 did not report immediately and as work with other resident and a half to two and investigation was not investig | ring other staff and residents stated she has interviewed her residents. She was stigation was started. She it 10:00 a.m. She was asked on was completed. She 21. She was asked if a on was conducted. She thorough." She was asked if lessed after incident for stated, "No."  In CNA #2 had worked on it is stated, "No."  In CNA #2 had worked on had worked | F                      | 835  |                                   |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |         |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|--|---------|--|-------------------------------|----------------------------|
|   |   | 375488   | B. WING                                | B. WING |  |                               | 01/ <b>2021</b>            |
| NAME OF PI  | ROVIDER OR SUPPLIER   |  | •                                      | 3       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>801 SOUTH OAKWOOD ROAD<br>ENID, OK 73706                            | ,                             |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     |         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 835   | pressure ulcer to the vacuum (vac) and part A time record for RN documented she wor a.m.  A time record for CN documented she wor a.m.  A progress note, date documented, "She she was raped by 50 minutesStaff is not themselves. This was per policy"  On 06/28/21 at 5:20 observed to be at the When approached, the a call that a resident They were asked who call. One stated, "At 5:25 a.m., the admitalk to you guys." She was raped by 50 minutesStaff is not themselves. This was per policy" | diagnoses which included sacrum requiring a wound ain.  #2, dated 06/27/21, red from 5:33 p.m. to 5:39  A #5, dated 06/27/21, red from 10:01 p.m. to 5:39  ed 06/28/21 at 4:23 a.m., than [sic] began saying that remales every 30 to go in her room by so reported to administration  a.m., two police officers were refront door to the facility. They stated they had received had been sexually abused. They had received the pout five minutes ago."  ministrator stated, "I need to be stated, "We have a crazy as raped and I didn't send | F                                      | 835     |  |                               |                            |
|   | documented, "Fina<br>of Abuse/Mistreatme<br>IncidentResident m<br>being raped by 50 pe  | eport, dated of 06/27/21, I[Resident #8]Allegations ntDescription of nakes allegation that she was exple every 30 minutes. She were trying to poison her   |  |         |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′   | PLE CONSTRUCTION    | , ,   | (X3) DATE SURVEY COMPLETED |                            |
|---|---|---|---------------------|---|----------------------------|----------------------------|
|   |   | 375488  | B. WING             |   |                            | C<br><b>07/01/2021</b>     |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                         |                            | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |
| F 835   | when staff CMA gave [signs/symptoms] of day and final reports of the investigation  A report summary, d completion 06/28/21 "Who is/are the rep woman and 50 of the happenedAccusati bugsWhat was dor from further harmS room 2 at a timeW of the incidentNotif the resident's curren statusAssessment 06/28/21When was supervisor/managen about the incident  A statement from RN "2305-2315 [11:05 began saying that the The bed was checked sign of bugs. She the she was raped. She allegations. She sai woman and there is She cannot really degoing in her room will being told by Admini in with 2 Licensed not a statement from CN 12:32 p.m., document #8] started yellingS yelling rape. She sai everyone has been in | e her ultramNo S/S physical rape notedFor 5 physical rape notedFor 5 please include a summary see attached  ate and time of report at 5:10 p.m., documented, borted perpetrator(s)A  emWhat ion of Rape and bed he to protect the resident(s) Staff was to always go in hat was done upon discovery fied AdministratorWhat is t physical done at 5PM s facility hent staff first contacted 11:47 PM [06/27/21]"  If #2 documented, p.m. to 11:15 p.m.] Resident here was bed bugs in her bed. and by 2 staff and found no han [sic] began saying that has been yelling these d that the rapest [sic] is a 50 of them every 5 minutes. here is people and then after stration we have been going | F 83                | 35  |                            |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIP   | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED  |                   |
|--|--|---|---------------------|--|-------------------|
|  |  | 375488  | B. WING             |  | C<br>07/01/2021   |
| NAME OF PR   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706                              | ,                 |
| (X4) ID<br>PREFIX<br>TAG   | EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION |
| F 835  | documented, "Resid abused and raped resident abused and raped resident abused and raped resident abused and raped resident #8's room rape multiple times coming"  On 06/28/21 at 6:27 had received a text rapes last night at 11 resident's wound vac was observed to be from the charge nurse when the nurse went resident alleged rapes the nurse had inform to go in there alone, told the nurse to go a get a description of with the nurse told the A | 06/28/21, from CNA #7,<br>ent stated she was being  | F 83                | ,  |                   |
|  | "looks like us."  The ADM was asked with the resident last She stated she had it the family and physic resident. She stated assessed. The adminurse, "You can't rapiclose to." She was a   | I how many staff had worked inight. She stated, "Two." instructed the nurse to inform cian and to assess the ithe resident refused to be inistrator stated she told the se someone you can't get asked who the two staff were any with the resident. She and an RN. |                     |  |                   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | A. BUILDIN   | PLE CONSTRUCTION  IG |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|----------------------|--|-------------------------------|----------------------------|
|  |   | 375488   | B. WING _            |  |                               | C<br>07/01/2021            |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706            |                               | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 835  | residents once she allegation of rape. Swith two, always two facility policy was for was an allegation of find the policy." She reading it. She state them, suspend." She two staff had been sat the time." She stated, "I don't She was asked what She stated, "I don't She was asked if he employees for alleg followed. She stated. On 06/29/21 at 11:3 regarding resident # reviewed with the Allher report on the state texted her that the reporterators as "loo investigative report unable to give a des "Yes", referring to the information. She we concerned about the "What does the reported to her the of "looks like us" and the resident was unable the to give a des "Yes", and the resident was unable the the of "looks like us" and the resident was unable there was no response. | d how she protected the was made aware of the She stated, "I told her to go in o." She was asked what the r protecting residents if there is abuse. She stated, "Let me elocated the policy and began ed, "Immediately remove he was asked if either of the suspended. She stated, "Not ated, "I came and did it later." at time she suspended them. know, I was with the police." er policy for suspending ations of abuse had been d, "No."  O a.m., the investigation is allegation of rape was DM. She stated she based aff statements.  ADM her interview from the reported the charge nurse esident described the ks like us" and that the documented the resident was scription. The ADM stated, are discrepancies in the stated of the charge nurse esident described the was a discrepancies. She stated, but say." Reviewed her erday that she stated the nurse description the resident stated the report documented the et o describe the perpetrator. | F8                   | 35   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ' '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY COMPLETED |                            |
|---|--|--|---|--|----------------------------|----------------------------|
|   |  | 375488   | B. WING                                 |  |                            | C<br><b>07/01/2021</b>     |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706              | I                          | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 835   | facility all night after to resident identifying the who raped her.  The facility failed to he investigation into the statement of the stateme | the allegation of rape and the the RN and CNA as the ones ave an accurate a thorough allegations.  It is agnoses which included and the included are the includ | F 8                                     | 35   |                            |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  IG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|----------------------|---|-------------------------------|----------------------------|
|  |  | 375488   | B. WING _            |   | C<br>07/01/2021               |                            |
| NAME OF PI   | ROVIDER OR SUPPLIER  |  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706             | <u> </u>                      | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 835  | worked on 03/23/21  A final OSDH report at 6:38 p.m., documday and final reports of the investigation investigation attached safe surveys were con 03/23/21. The foasked:  1. Do you feel like wilght, you get everyth 2. Have you heard sanguage?  3. Has staff ever yel  | N #1 documented she from 5:42 a.m. to 2:34 p.m.  If faxed to OSDH on 03/23/21 ented the followingFor 5 is, please include a summary increase. Sheet attached, ed"  If the following and th | F8                   | 35  |                               |                            |
|  | No negative answer  LPN #1 reamained was verbal abuse had be invesitigation.  There were no writted reporting staff member or other staff with the administrator document the staff member may others. She documented for the staff member who had mem | en staff statements from the per, the perpetrator (LPN #1) the investigation. The pented that she had spoken to aking the allegation and three ented she spoke with resident d the only person who comments was the staff ade the allegation. The pented her conclusion was the  |                      |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   | 375488   | B. WING _           |  | C<br>07/01/2021               |                            |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 SOUTH OAKWOOD ROAD<br>ENID, OK 73706        |                               | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 835   | when LPN #1 worke she worked til 3:21 p did the LPN receive. She was asked whe completed. She star completed, but the completed, but the completed, but the completed stated there was completed, but the completed stated there was completed and LPN #1. She worked during the instated, "Yes." She was asked, how protected if the LPN investigation. She seminterviewed and he allegation could asked if was reported not notified until the On 06/25/21 at 3:09 asked if she recalled She stated she did. cursed at the resident that he had fallen. So "Jesus F*** Christ, [I asked who she had stated she reported and that her supervival administrator.  The facility failed to investigation of abuse a allegation to the admagencies timely. | p.m., the DON was asked d on 03/21/21. She stated o.m. What disciplinary action The DON stated, "None." In the investigation had been ted the investigation was locumentation was not. She offlict between the activity aide as asked if LPN #1 had vestigation. The DON was asked what was put in occurrence and to protect the ed there were no changes. It is residents had been worked during the stated the complainant was laid a discussion about how not have occurred. She was dimely. She stated she was | F8                  | 35   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′   | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED  |                        |
|---|---|---|---------------------|--|------------------------|
|   |   | 375488  | B. WING             |  | C<br><b>07/01/2021</b> |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                                | 07/01/2021             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION      |
| F 835   | diagnoses which inc  A quarterly resident indocumented the resimpaired.  A state incident report documented, "Res #1]Incident Type  Abuse/Mistreatment  A notification of nurs 06/12/21, documented employee terminated 06/12/2021ALLEG ABUSEOn June 12/11:00 am a incident member in which a Finvolved. CNA #1 reshoe for her and she personal SnapChates does your resident ereason??" The capt laughing face emojic was terminated for notical violation of our facility.  On 06/23/21 at 8:59 when were the staff phone use and social inserviced when they She was asked what media restrictions we anything about resident are the staff were inserviced when in resident are the staff were inserviced were inserviced when in resident are the staff were inserviced were inserviced were inserviced when in resident are the staff were inserviced were ins | assessment, dated 06/12/21, dent's cognition was severely of the form, dated 06/12/21, identInvolved[resident Allegations of"  e aide report, dated ed, "CNA #1was dYestermination date | F 83                |  |                        |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '   | PLE CONSTRUCTION  G | , ,  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|---------------------|--|-------------------------------|----------------------------|
|   |  | 375488  | B. WING             |  |                               | C<br><b>07/01/2021</b>     |
| NAME OF P   | ROVIDER OR SUPPLIER  | 2.0.00  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                          | I                             | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| F 835   | July. She stated the they had to wait for they had to were put in residents from further they weren't.  On 06/24/21 at 2:00 what staff were interview working that same shaff members were thorough investigation. She was protected from further they did not initiate at A thorough investigal related to this incider if any other staff or resident from the Company of th | y were going to in June but heir board's approval of the was asked if any corrective in place to protect the roccurrence. She stated  p.m., the DON was asked viewed as part as their rated CMA #1. She stated of other staff who were hift. She was asked if other not interviewed, was a nompleted. She stated, as asked how residents were ar occurrence. She stated my new interventions.  Ition had not been completed hit. As a result, it is unknown esidents had been involved.  For form, dated 07/24/20, for Filing Complaint[CMA concernWeekend staff int] when she came out of her call walk her back, close her in [and] hold the door so she is eventually came out again, aide grabbed her walker, dil said "I'm tired of this shit. anything, she was bullied | F 83                | 35   |                               |                            |

| AND DI AN OF CORRECTION IDENTIFICATION NUMBER: |  | , ,   | PLE CONSTRUCTION  G | ' '   | (X3) DATE SURVEY COMPLETED |                            |
|--|--|---|---------------------|---|----------------------------|----------------------------|
|  |  | 375488  | B. WING             |   |                            | C<br><b>07/01/2021</b>     |
| NAME OF P                                      | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                         |                            | 0770172021                 |
| (X4) ID<br>PREFIX<br>TAG                       | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 835  | her and when [reside they put a mask on h goResolution[CM discuss her allegatio didn't back those alle employee warning for misrepresentation 2) manner contrary to morality [and] decend concern form] When refused to do anythin F words. Would thromake [CMA #4] pick every weekend she hincident happened of anonymouswants to the words. Would thromake [CMA #4] pick every weekend she hincident happened of anonymouswants to the words. Would thromake [CMA #4] pick every weekend she hincident happened of anonymouswants to the words | ent] comes out of her room, her and let her la#4] was called in to hes. Was informed the video egations up. She received an or 1) dishonesty, conducting one self in a ecognized standards of cy[On the back of the [CMA #4] told the nurse, she had [and] just said a bunch of low things off the desk [and] them upThis happened has workedThis specific in 7/19/20Wants to remain to be notified of resolutions"  If you have a conducting the properties of the conduction of | F 83                | 35  |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ` ′   | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|---------------------|---|-------------------------------|----------------------------|
|   |   | 375488  | B. WING             |   |                               | C                          |
| NAME OF PI  | ROVIDER OR SUPPLIER   | 0,0400  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706                           |                               | 07/01/2021                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| F 835   | reported to if the DC stated they can alward phone.  On 06/24/21 at 11:1 she witnessed abus month or two ago ar She was asked whe She stated staff typi of command but the abuse was her chain to state the incident She was asked if she She stated she was hold it against her.  On 06/25/21 at 9:50 she had ever felt like incidents of allegation "Yeah." She stated, be more in trouble for At 3:09 p.m., the act had ever felt like she of abuse. She stated stated, "Last time I reblew me off."  On 06/28/21 at 3:20 #1 and ADM were an investigation related 07/24/20. SS#1 staffrom CMA #4.  The ADM stated the | She was asked who they on was not in the facility. She ays reach her on her the cell of a.m., CMA # 3 was asked if the and she reported it to the ADM. In and who did she report to cally report through the chain person who had done the not command. She went on was "traumatizing to me." the was afraid to report abuse. It worried that someone would worried that someone would the she could not report ons of abuse. She stated, "Sometimes things don't get "We feel like people should or certain things."  It witty aide was asked if she the could not report allegations in | F8                  | 35  |                               |                            |
|   |   | 07/19/20. She was asked if it<br>he stated they looked at the   |                     |   |                               |                            |

|  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |  |
|--|---|--|--|---|---|-------------------------------|----------------------------|--|--|
| THE COMMONS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835  Continued From page 135 whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "Yes." She was asked why.  SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] because, in her opinion, it was retaliation against  |   |  | 375488   | B. WING _                               |   |                               |                            |  |  |
| FREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835  Continued From page 135  whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No."  They were asked if CMA #4 received disciplinary action. The ADM stated, "Yes." She was asked why.  SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against |   |  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD |                               |                            |  |  |
| whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No."  They were asked if CMA #4 received disciplinary action. The ADM stated, "Yes." She was asked why.  SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against   | PREFIX  | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL   | PREFIX                                  | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE               | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |  |  |
| remain anonymous.  On 06/29/21 at 7:02 p.m., CMA #3 was asked if she was fearful of reporting allegations of abuse. She stated, "Yes and No." She stated if LPN #3 was aware, I'd be afraid she'd come back at me."  | F 835   | whole day. She was thoroughly investigated. They were asked if Caction. The ADM stated why.  SS #1 stated the DOI The ADM stated in he ADON] thought CMA from what she remen ADON] thought it was stated she argued with because, in her opinithe staff member. She remain anonymous.  On 06/29/21 at 7:02 she was fearful of rep She stated, "Yes and | asked if the incident was ed. The ADM stated, "No."  EMA #4 received disciplinary ted, "Yes." She was asked  N and ADON had decided. er opinion, they [DON and #4 was lying. SS#1 stated, nbered, they [DON and s a fraudulent report. SS#1 th them [DON and ADON] on, it was retaliation against he stated CMA #4 wanted to p.m., CMA #3 was asked if porting allegations of abuse. No." She stated if LPN #3 | F8                                      |   |                               |                            |  |  |

Oklahoma State Department of Health

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                      | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|----------------------|---|-------------------------------|--------------------------|
| AND PLAN                 | OF CORRECTION   | IDENTIFICATION NUMBER.   | A. BUILDING: _       |   | COMPLETE                      | ED                       |
|                          |   | NH2407   | B. WING              | B. WING   |                               | 2021                     |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADD   | DRESS, CITY, STA     | TE, ZIP CODE  |                               |                          |
| THE COM                  | MONS  | 301 SOUT<br>ENID, OK   | H OAKWOOD F<br>73706 | ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL000                    | 00 Initial Comments   |  | LL000                |   |                               |                          |
| 11 067                   | through 07/01/21, the Department of Health Focused Survey to decompliance with imple prevention and controdevelopment and transcomplaints #OK0005#OK00056691 were in with the survey.   | a completed a COVID-19<br>etermine if the facility was in<br>ementing proper infection<br>of practices to prevent the<br>asmission of COVID-19.<br>6688, OK00057230 and<br>anvestigated in conjunction | LL067                |   |                               |                          |
| ELOO                     | A facility employee or agent who becomes aware of abuse, neglect or exploitation of a resident prohibited by the Nursing Home Care Act shall immediately report the matter to the facility administrator. A facility administrator who becomes aware of abuse, neglect, or exploitation of a resident shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department.  |  |                      |   |                               |                          |
| Oklah awa Str            | This Rule is not met as evidenced by: On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to develope and implement an abuse policy and procedure that promoted an environement where allegations of abuse could be made without fear of retailiation, residents were protected/free of abuse and neglect, allegations were reported timely to the administrator and other agencies, allegations were throughly investigated and corrective measuers were taken to prevent further abuse. |  |                      |   |                               |                          |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CO   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED  |                          |
|---|--|--|--|---|--------------------------------|--------------------------|
|   |  | NH2407   | B. WING                                  |   | 07                             | C<br>7/ <b>01/2021</b>   |
| NAME OF F   | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATE                      | , ZIP CODE  |                                |                          |
| THE COM   | IMONS  |  | JTH OAKWOOD RO<br>K 73706                | AD  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067   | refusing/withholding #9. The allegation wadministrator and a troot conducted. The eduring the investigatia against the nurse.  An allegation of staff resident #7 on 02/22 02/23/21, one day af The residents were remember was allowed. The facility document being physically abust reported by staff. The resident, complete a implement corrected abuse.  Resident #8 made and on 06/28/21 and the continue to work over allegation was made.  Staff witnessed verban employee and reproted to the action of the action of the action of the investigation of the investigation was while the investigation of th | ed that LPN #3 had been pain medications to resident has not reported timely to the horough investigation was employee remained working on and no action was taekn being verbally abusive to /21 was not reported until ter the allegation occured. Not protected as the staff of to work.  Ited an incident of resident #5 seed by staff witnessed and he facility failed to protect the thorough investigation and measures to prevent further hallegation of rape by staff staff had been allowed to r six hours after the horough investigation was dministrator timely and a now was not conducted. The rotected due to the grat work and continued to digition was on going. | LL067                                    |   |                                |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 2 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|---------------------|---|-------------------------------|--------------------------|
|   |  |  | A. BUILDING:        | A. BUILDING:  |                               |                          |
|   |  | NH2407   | NH2407 B. WING      |   | 07                            | C<br>/ <b>01/2021</b>    |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATE | E, ZIP CODE   |                               |                          |
| THE COM   | IMONS  | 301 SOU  | TH OAKWOOD RO       | DAD   |                               |                          |
| THE COM   | INIONS   | ENID, OF   | 73706               |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page  | e 2  | LL067               |   |                               |                          |
|   | provided by the admin p.m. It documented to "Plan of AMENDED FOR THESE items will be 2021 [By 8:00 p.m.] Misappropriation InvestigatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Jountil in serviced, by the ADON [assistant direction outside agency. Due 06/28/21 [staff name] | Removal for IJ's - ALL<br>completed by June 30th,<br>Abuse, Neglect,<br>estigation POLICY was  |                     |   |                               |                          |
|   | the INCIDENT RESP and includes the Adm Administrator, DON, A Center Resident serv administrator or design Director any allegation scheduled monthly medical monthly medical months and outside source on including screening, protection 06/30/21 with advantage and months always protect our response team will medical months.                            | ADON, and HealthCare ices Director. The gnee will report to Board of n of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ng, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and is to ensure all thorough |                     |   |                               |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 3 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ' '   | CONSTRUCTION        |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|---------------------|--|-------------------------------|--|
|   | NH2407 B. WING  |   | C<br>07/01/2021     |  |                               |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STA   | TE, ZIP CODE                             |                               |  |
| THE COM   | MONE  | 301 SOU   | TH OAKWOOD F        | ROAD                                     |                               |  |
| THE COM   | MONS  | ENID, OF  | 73706               |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE |                               |  |
| LL067   | were interviewed and information related to administrative staff we able to state accurate abuse and neglect.  The immediate jeopar of 06/30/21 at 5:10 p. plan of removal and thad been implemente remained at a level of Based on observation and staff interviews, it failed to develop and procedure for abuse the conducting thorough conducting the residual conducting the residual consistency and staff were actions for six [#1, 5, sampled residents reviews]. | As, one RN and three CMAs able to state accurate abuse and neglect and five ere interviewed and were information related to a movement of the amended plan of removal ed. The deficient practice fractual harm at a pattern.  In, record review and resident the was determined the facility implement a policy and by not:  Degations timely, and investigations, dents, ective measures and exheld accountable for their 6, 7, 8 and #9] of six | LL067               |  |                               |  |
|   | facility. Findings:   |   |                     |  |                               |  |
|   | preventabuse byF  | Company actively works to<br>Protecting employeesfrom<br>they do the right thing and  |                     |  |                               |  |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 4 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION                                 |                  |   | (X3) DATE SURVEY<br>COMPLETED   |                  |  |
|---|---|--|------------------|---|---------------------------------|------------------|--|
| 741012741   | or correction.  | IBERTIN IO/MICITALIMBELA.                                  | A. BUILDING: _   |   |                                 |                  |  |
|   |   |  |                  |   |                                 | С                |  |
|   |   | NH2407   | B. WING          |   | 07                              | 7/01/2021        |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, STA | TE, ZIP CODE  |                                 |                  |  |
|   |   | 301 SOUT   | H OAKWOOD F      | ROAD  |                                 |                  |  |
| THE COM   | MONS  | ENID, OK   | 73706            |   |                                 |                  |  |
| (X4) ID   | SUMMARY STA   | ATEMENT OF DEFICIENCIES                                    | ID               | PROVIDER'S PLAN OF  | CORRECTION                      | (X5)             |  |
| PREFIX<br>TAG   | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | COMPLETE<br>DATE |  |
| LL067   | Continued From page   | ÷ 4  | LL067            |   |                                 |                  |  |
|   |   |  |                  |   |                                 |                  |  |
|   |   | ne Company strictly prohibits                              |                  |   |                                 |                  |  |
|   |   | n, against any individual<br>plaint, or inquiry in good    |                  |   |                                 |                  |  |
|   |   | ct PolicyNO FORM OF  |                  |   |                                 |                  |  |
|   |   | T IS TOLERATED AND   |                  |   |                                 |                  |  |
|   | MUST BE REPORTE   |  |                  |   |                                 |                  |  |
|   |   | URE TO REPORT ABUSE  |                  |   |                                 |                  |  |
|   |   | N SUSPECTED ABUSE OR                                       |                  |   |                                 |                  |  |
|   | i i   | YOU RESPONSIBLE FOR  |                  |   |                                 |                  |  |
|   | THE SITUATIONBullying & HarassmentThe Commons will not, in ay instance, tolerate bullying |  |                  |   |                                 |                  |  |
|   |   |  |                  |   |                                 |                  |  |
|   | _   | r. Employees found in                                      |                  |   |                                 |                  |  |
|   |   | will be disciplined, up to and                             |                  |   |                                 |                  |  |
|   | _   | examples of bullying                                       |                  |   |                                 |                  |  |
|   | and/or harassment:  |  |                  |   |                                 |                  |  |
|   |   | ımiliatingShouting, raising                                |                  |   |                                 |                  |  |
|   |   | n publicTelephone Calls &                                  |                  |   |                                 |                  |  |
|   | time onlyCode of Co   | one use is limited to break                                |                  |   |                                 |                  |  |
|   | ProceduresViolation   |  |                  |   |                                 |                  |  |
|   |   | orrective action being taken,                              |                  |   |                                 |                  |  |
|   | _   | schargePhysical or mental                                  |                  |   |                                 |                  |  |
|   |   | s or failure to report physical                            |                  |   |                                 |                  |  |
|   | or mental abuse by of   |  |                  |   |                                 |                  |  |
|   | MediaEmployees m  | nust not post  |                  |   |                                 |                  |  |
|   | confidentialaboutd  | clientsEmployees should                                    |                  |   |                                 |                  |  |
|   | not disparage any per   | rsonbased ondisability"                                    |                  |   |                                 |                  |  |
|   | An abuse policy, date   | ed 12/08/2020, documented,                                 |                  |   |                                 |                  |  |
|   | "Reporting Requireme  | entsallegations shall be                                   |                  |   |                                 |                  |  |
|   |   | to the administrator, DON                                  |                  |   |                                 |                  |  |
|   |   | n accordance with State                                    |                  |   |                                 |                  |  |
|   |   | involve abusemust be                                       |                  |   |                                 |                  |  |
|   | •   | rsThese allegations must                                   |                  |   |                                 |                  |  |
|   |   | gated and must prevent                                     |                  |   |                                 |                  |  |
|   |   | e while the investigation is in                            |                  |   |                                 |                  |  |
|   |   | e action must be taken                                     |                  |   |                                 |                  |  |
|   |   | e appropriate licensing                                    |                  |   |                                 |                  |  |
|   |   | t [sic] the policy of The<br>resident will be free from    |                  |   |                                 |                  |  |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 5 of 227

Oklahoma State Department of Health

|   |                       |  | 1               |  | 1       | 1                |
|---|-----------------------|--|-----------------|--|---------|------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) MULTIPLE CONSTRUCTION                         |                 | (X3) DATE SURVEY<br>COMPLETED                                |         |                  |
| AND PLAN (  | OF CORRECTION         | IDENTIFICATION NUMBER:                             | A. BUILDING: _  |  | COMPLE  | IEU              |
|   |                       |  |                 |  | C       |                  |
|   |                       | NH2407   | B. WING         |  |         | /2024            |
|   |                       | NH2407   | 1               |  | ı 07/01 | /2021            |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA | TE, ZIP CODE   |         |                  |
|   |                       | 301 SOUTI  | H OAKWOOD I     | ROAD   |         |                  |
| THE COM   | MONS                  | ENID, OK   |                 |  |         |                  |
|   |                       | ·  |                 |  |         |                  |
| (X4) ID   |                       | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID              | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD |         | (X5)<br>COMPLETE |
| PREFIX<br>TAG   | •                     | LSC IDENTIFYING INFORMATION)                       | PREFIX<br>TAG   | CROSS-REFERENCED TO THE APPROPR                              |         | DATE             |
|   |                       | ,  | 1710            | DEFICIENCY)  |         |                  |
|   |                       |  |                 |  |         |                  |
| LL067   | Continued From page   | e 5  | LL067           |  |         |                  |
|   | abuse neglectAll fa   | acility staff will be in-serviced                  |                 |  |         |                  |
|   |                       | nt, and at least annually                          |                 |  |         |                  |
|   | thereafter, regarding | <del>_</del>                                       |                 |  |         |                  |
|   |                       | report any suspicion of                            |                 |  |         |                  |
|   |                       | streatment to your immediate                       |                 |  |         |                  |
|   | _                     | <u>-</u>   |                 |  |         |                  |
|   |                       | ervisor WILL CALL the CELL                         |                 |  |         |                  |
|   |                       | STRATOR [admin], then the                          |                 |  |         |                  |
|   | •                     | substantiated cases must                           |                 |  |         |                  |
|   | •                     | espective agencies such as                         |                 |  |         |                  |
|   | •                     | nforcement, physician;                             |                 |  |         |                  |
|   |                       | ent responsible party. The                         |                 |  |         |                  |
|   | -                     | l be routinely and openly                          |                 |  |         |                  |
|   | •                     | tionProcedure1stCare                               |                 |  |         |                  |
|   |                       | CT the resident-DON,                               |                 |  |         |                  |
|   | ADON, or house supe   | ervisor should do a medical                        |                 |  |         |                  |
|   |                       | telydocumenting any injury                         |                 |  |         |                  |
|   | in detailTake a state | ement from the                                     |                 |  |         |                  |
|   | resident2ndIsolate    | e the perpetrator3rd                               |                 |  |         |                  |
|   | Immediately notify t  | the Administrator, then DON                        |                 |  |         |                  |
|   |                       |  |                 |  |         |                  |
|   |                       |  |                 |  |         |                  |
|   | 1. Resident #9 had d  | liagnoses which included                           |                 |  |         |                  |
|   | chronic pain and oste | eoarthritis.                                       |                 |  |         |                  |
|   | -                     |  |                 |  |         |                  |
|   | A resident assessmer  | nt, dated 01/14/2021,                              |                 |  |         |                  |
|   | documented the resid  | dent's cognition was                               |                 |  |         |                  |
|   | moderately impaired.  | <b>-9</b>  |                 |  |         |                  |
|   |                       |  |                 |  |         |                  |
|   | A care plan effective | date 01/07/21, documented,                         |                 |  |         |                  |
|   | "Resident is at risk  |  |                 |  |         |                  |
|   | muscle spasms and c   |  |                 |  |         |                  |
|   | syndromeResident      | •  |                 |  |         |                  |
|   |                       | imely mannerAdminister                             |                 |  |         |                  |
|   | medications as presc  |  |                 |  |         |                  |
|   | medications as presc  | nbed   |                 |  |         |                  |
|   | Dhygigian's arders de | atod 06/08/21 dogumented                           |                 |  |         |                  |
|   |                       | ated 06/08/21, documented,                         |                 |  |         |                  |
|   |                       | [milligrams]-acetaminophen                         |                 |  |         |                  |
|   |                       | ) give 1 tablet by oral route                      |                 |  |         |                  |
|   | every 8 hours as need | ded FOR CHRONIC PAIN                               |                 |  |         |                  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '  | CONSTRUCTION        | (X3) DATE S   |       |                          |
|---|---|--|---------------------|---|-------|--------------------------|
| AND FLAN  | OF CORRECTION   | IDENTIFICATION NOMBER.   | A. BUILDING: _      |   | COMPL | ETED                     |
|   |   | NH2407   | B. WING             |   | 07/0  | )<br>1/2021              |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |       |                          |
| THE COM   | MONS  | 301 SOUTI<br>ENID, OK  | I OAKWOOD I         | ROAD  |       |                          |
|   |   | ·  | 73706               |   |       |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROFINE DEFICIENCY) | D BE  | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page   | e 6  | LL067               |   |       |                          |
|   | Tylenol 325 mg capsuroute every 6 hours a   | ale give 2 tablets by oral s needed for pain   |                     |   |       |                          |
|   | Ultram 50 mg tablet g<br>route every 6 hours a  | ive 1 tablet (50 mg) by oral<br>s needed for pain"   |                     |   |       |                          |
|   | 12:35 a.m., documen multiple occasions, ty in the morning after the [Resident #9] get up of ask for a pain pill. He Norco and rate his part butt pain. As protoco request to the charge go to the resident to be report back to me, the administer a pain med level of the pain that a location of the [sic] pain [LPN #3], will deny the name], pain meds standoesn't need a pain pamoke a cigarette, he | out of bed for the day, he will will specifically ask for a sin at an 8 out of 10 for leg or I, as the CMA, I report the nurse, the charge nurse will evaluate the resident and e CMA, with guidance to d and instruct me with the was reported and the n. On many occurances, e resident, [Resident's ting 'He just got up, he ill' or 'He's going outside to the sin to the sin the solution of the solution |                     |   |       |                          |
|   | pain pill because he h<br>On these occurances   |  |                     |   |       |                          |
|   | Abuse/Mistreatment<br>IncidentStaff reported<br>pain meds when resident is cognitive<br>called"   | dent #9]Allegations of<br>.Description of<br>ed Nurse not approving PRN<br>dent asked for them.<br>and needs no family   |                     |   |       |                          |
|   | ⊢A statement from LPN   | N #3, dated 06/27/21 at  | 1                   |   |       |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | , ,   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|--|--|-------------------------------|--|
|   |   |   | D WING                                   |  | С                             |  |
|   |   | NH2407  | B. WING                                  |  | 07/01/2021                    |  |
| NAME OF PR  | ROVIDER OR SUPPLIER   |   | RESS, CITY, STA                          | •  |                               |  |
| THE COM   | MONS  | ENID, OK  | I OAKWOOD F<br>73706                     | ROAD   |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE                   |  |
| LL067   | pills when it is not tim is scheduled [every] & offered Tylenol if Nord Safe surveys were con The questions asked related to receiving particle documented the allegs and completed on 06. On 06/28/21 at 12:40 assistant administrate conclusion of the inversal administrator stated is spreadsheet of which versus the Norco. She had administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it withheld the medicatic conclusion the allegate She stated she went thim about it. She state nurse's biggest cheer. At 1:19 p.m., the ADM. There were no questioned the executive of surveys and thought the members respect your members respect your saked if the properties of | ent a.m. or p.m.], mes resident asks for pain e as he had it earlier. Med ß [hours] prn. Resident is co can't be given yet"  Inducted with five residents. Ito the residents were not ain medications. The facility fation was unsubstantiated (27/21 at 5:30 p.m.  p.m., the administrator and or were asked about the estigation. The assistant the had made an excel nurse had given Tylenol the stated the accused nurse medications as much as the as asked if there was times the resident had She stated she didn't think the had requested it. She was documentation of when the and the CMA stated LPN #3 ton, how did they come to the tion was unsubstantiated. Ito the resident and asked ted the resident is this leader.  If provided resident surveys. It provided resident surveys. It provided residents Iding pain medications. She | LL067                                    |  |                               |  |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  |                     | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|--|---|---------------------|---|-----------------|
| ANDILAN   | or dorate of the transfer of t | IDENTIFICATION NOMBER.  | A. BUILDING: _      |   |                 |
|   |  | NH2407  | B. WING             |   | C<br>07/01/2021 |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                 |
| THE COM   | MONS   |   | I OAKWOOD I         | ROAD  |                 |
|   |  | ENID, OK  | 73706               |   | T               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE     |
| LL067   | Continued From page  | 8   | LL067               |   |                 |
|   | On 06/29/21 at 6:35 p if he was in pain. He right side, leg and kne rate it at an 8 out of 1 a 9 in the mornings. Ihe did not get his Nor He stated, "If I don't g was asked if his Norc stated it was once. H now he gets it. He was member was who with stated he was not goi  | o.m., the resident was asked stated he had pain in his e.e. She stated he would o. He stated it was usually He was asked how he felt if co when he requested it. et them, I get mad." He o was ever withheld. He e stated he turned it in and as asked who the staff hheld the medication. He ng to tell. |                     |   |                 |
|   | At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me cause when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.   |   |                     |   |                 |
|   | abuse policy and productive accurate a thorough in allegations abuse. The develope and implement protecting residents for 2. Resident #7 was addiagnoses which inclusively disorder.   | ne facility further failed to ent an abuse policy for rom abuse and negeclt.  Idmitted to the facility with uded convulsions and  |                     |   |                 |
|   |  | ssessment, dated 02/18/21,<br>lent's cognition was severely   |                     |   |                 |

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Oklahoma State Department of Health

| A. BUILDING:   | C<br>/01/2021            |
|--|--------------------------|
| R WING   |                          |
| NH2407 B. WING 07  |                          |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |                          |
| THE COMMONS  301 SOUTH OAKWOOD ROAD  ENID, OK 73706  |                          |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5)<br>COMPLETE<br>DATE |
| A state incident report form, dated 02/23/21, documented, "Incident TypeAllegations of Abuse/MistreatmentDescription of IncidentAdministrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progressFor 5 day and final reports, please include a summary of the investigationand corrective measures implemented to prevent recurrenceSee attached for investigation. Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information"  The allegation of abuse was not reported to the administrator until the next day after it occurred.  The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).  A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair up closer to the nurse's station area and parked hims |                          |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CO   |                     |   | E SURVEY<br>PLETED                |                          |
|---|---|--|---------------------|---|-----------------------------------|--------------------------|
|   |   |  |                     |   | С                                 |                          |
|   |   | NH2407   | B. WING             |   | 07                                | 7/01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, STATE | , ZIP CODE  |                                   |                          |
| THE COM   | MONS  |  | TH OAKWOOD RO       | AD  |                                   |                          |
|   |   | ENID, OK   | 73706               |   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page   |  | LL067               |   |                                   |                          |
|   | talk to me that way." [resident #7] wheeled nurse's station area b his roomDuring this  | t of here, you're not going to After this occurrence, I himself away from the back down the hall towards coccurrence, [CMA #4] was de me and witnessed the   |                     |   |                                   |                          |
|   | documented, "On Mo #4] came into work I was sitting at nurses statio came strolling up to the nurses station [LPN # around and go back I said I dont care Im no and he said he wanted screamed at him and your [sic] not sitting undeal with your Ass. so | y CMA #4, dated 02/24/21, nday February 22nd I [CMA was on North Hall. I was on [resident #7] the resident he Common Area by the #3] the nurse told him to turn he said he has rights She ot gonna [sic] deal with you ed to sit up here She said "I dont give a dam [sic] p here Im not gonna [sic] to [resident #7] sat in the ft he was very upset the rest |                     |   |                                   |                          |
|   | documented, "The ot<br>getting something wh<br>at [resident #7]. And<br>[Resident #7] started<br>#3] got louder and tol   | y CNA #3, dated 02/24/21,<br>her day I was in the office<br>en I heard [LPN #3] yelling<br>telling him to go to his room.<br>yelling back at her and [LPN<br>d him she wasn't going to<br>r room. [LPN #3] then said<br>like this"   |                     |   |                                   |                          |
|   | 5:00 p.m., documente<br>[administrator (admin<br>back [and] was told the<br>against me for yelling<br>Monday February 22<br>[approximately] [2:00   | y LPN #3, dated 02/24/21 at ed, "Missed a call from )] [at] the Commons. Called here was an allegation [at] a male on North Hall on hol [at] approx p.m.]Not only did I yell [at] dly I cussed [at] him also per   |                     |   |                                   |                          |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE C   |                     |   | SURVEY<br>PLETED                |                          |
|---|---|---|---------------------|---|---------------------------------|--------------------------|
|   |   | A. BUILDING:  |                     |   |                                 |                          |
|   |   | B. WING   | B WING              |   | С                               |                          |
|   |   | NH2407  | B. WING             |   | 07                              | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, STATE | E, ZIP CODE   |                                 |                          |
| THE COM   | IMONS   | 301 SOU   | TH OAKWOOD RO       | DAD   |                                 |                          |
| THE COM   | INIONS  | ENID, OK  | 73706               |   |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page   | = 11  | LL067               |   |                                 |                          |
|   | told I told male reside<br>hall or go to his room<br>to sit in the area by w<br>it congests the hallwa<br>towards the resident.   |   |                     |   |                                 |                          |
|   | "Who is/are the rep #7]Who is/are the rep #7]Who is/are the re #3]Who witnessed is [CNA #3], [CMA #4] happenedResident. sitting near the nurse came down the hall a leave the deskWha resident(s)? Was the resident has had outbreason a staff member A staff member should this incident was not victim want to happer discuss the incident, I would like to happen, shoulderWhen did to 2pm on Feb [Februar | was in his wheelchair 's desk. [LPN #3] the nurse nd started yelling at him to t is the history of the incident foreseeableThe breaks lately, but there is NO er should yell at a resident. d Never yell at resident, but foreseeableWhat does the n[resident #7] would not but when asked what he he just shrugged his the incident happenAround y] 22ndWhen was facility ment staff first contacted |                     |   |                                 |                          |
|   | An Oklahoma Board of submitted date 02/26. Name: [LPN #3]Did or Criminal Behavior. abuseDescription of suspended pending the returned to work on 0 disciplinary action writed a resident and for concontrary to recognize   | of Nursing complaint form, /21, documented, "Nurse's incident include MisconductYes: Patient f InvestigationLPN was the investigation and 2/26/2021. She received te up for raising her voice at inducting herself in a manner  |                     |   |                                 |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  |                     | (X3) DATE SURVEY<br>COMPLETED   |             |
|---|--|--|---------------------|---|-------------|
|   |  |  | A. BUILDING: _      |   |             |
|   |  | NUI 0 407  | B. WING             |   | C           |
|   |  | NH2407   | B. W. C             |   | 07/01/2021  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, STA   | TE, ZIP CODE  |             |
| THE COM   | MONS   | 301 SOU  | TH OAKWOOD F        | ROAD  |             |
| THE COM   | WONS   | ENID, OF   | 73706               |   |             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE |
| LL067   | Continued From page  | e 12   | LL067               |   |             |
|   | 02/27/21, documente p.m. on 02/22/21. LF 4 hours and 48 minut  The facility failed to p abuse during the inve  | period from 02/14/21 to d LPN #3 worked til 6:48 PN #3 worked approximately es after the abuse occurred.  Protect residents from further estigation.  Proof the allegation timely to a through investigation was |                     |   |             |
|   | to describe the incide 02/22/21 with resident resident is hard of he didn't yell. She stated took statements from and discussed the incide. She was asked 02/22/21. She stated asked when the incide stated she was notified was asked what the cowas. She stated it was did it. She stated she write up. She was as tolerance for abuse. hand book is wrong." done to protect and p to other residents. Slanything else other the was asked who the stated asked when the staff did they report timely asked if the staff who |  |                     |   |             |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |           |                          |
|---|--|---|--|---|-----------|--------------------------|
|   |  |   | D WING                                   |   |           | С                        |
|   |  | NH2407  | B. WING                                  |   | 07        | /01/2021                 |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STATI                      |   |           |                          |
| THE COM   | MONS   | ENID, OK  | TH OAKWOOD RO                            | UAD   |           |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page  | ÷ 13  | LL067                                    |   |           |                          |
|   | verbal abuse happender p.m. She stated "Yest continued to work after was asked if LPN #3 or residents, how were the stated," They couldn't about it." She was as report the abuse immer protected. She stated after the incident. She was asked after the incident. She they worked with the victimal approximately four how the facility did not purplace to prevent abuse result, one of the with allegation of verbally atterminated CMA #4 we may be a courate a thorough in allegations abuse. The develope and implement protecting residents for the stated "She was accurated to work and they was a stated "She was a | if the resident was assessed e stated, "No."  no witnessed the abuse did to it. As a result, LPN #3 in and other residents for ours and 48 minutes.  It any corrective measures in the from reoccurring. As a sesses [CMA #4] had an abusing a different resident. In the allegation and while LPN #3 continued to be sity.  The evelope and implement and concept that allowed fo an an envestigation into the the facility further failed to the ent an abuse policy for som abuse. |  |   |           |                          |
|   | diagnoses which inclu  |   |  |   |           |                          |
|   |  | ssessment, dated 05/02/21,<br>lent's cognitive skills for   |  |   |           |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 14 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |                 |  |
|---|---|--|--|---|-----------------|--|
|   |   |  | A. BOILDING                              |   |                 |  |
|   |   | NH2407   | B. WING                                  | <del></del>   | C<br>07/01/2021 |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STAT                       | TE ZIP CODE   | •               |  |
| NAME OF T   | NOVIDEN ON 301 1 EIEN   |  | TH OAKWOOD R                             |   |                 |  |
| THE COM   | MONS  | ENID, OI   |  | NOAD  |                 |  |
| (X4) ID   | SUMMARY ST  | ATEMENT OF DEFICIENCIES  | ID                                       | PROVIDER'S PLAN OF CORRECT  | ON (X5)         |  |
| PREFIX<br>TAG   | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                            | (EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETE   |  |
| LL067   | Continued From page   | e 14   | LL067                                    |   |                 |  |
|   | daily decision making   | was severely impaired.   |  |   |                 |  |
|   | documented, "Resid#5]Incident TypeA Abuse/Mistreatment IncidentReceived at towards a resident by member suspended p  A written statement fr 06/07/21, documente #2] asked me if I coul yes just give me a se middle of taking care I walked into [residen | Description of allegation of abuse staff member. Staff pending investigation"  om CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had        |  |   |                 |  |
|   | on him while she was<br>bare skin I yelled at<br>way [and] she was lik<br>dropped him back on<br>his arm to get him up  | t arm yanking [and] pulling slapping at his left leg,-on her to stop doing him that e what [and] just kind of the bed, she went to pull on I told her to just leave that I m. I brought him out for  |  |   |                 |  |
|   | just happened. Wher<br>#2] she told her to sta<br>[resident #5]. When I<br>[10:00 a.m.] I asked it<br>[and] I told [DON] wha  | ne Charge Nursewhat had in [LPN #2] talked to [CNA in any away from direct care of seen [sic] D.O.Naround if [LPN #2] had talk to her talk had happened She told in a statement"   |  |   |                 |  |
|   | documented, "[CMA # yelled at [CNA #2] be me to help get him [re room where she was at her states she saw at his left leg so I told   | om LPN #2, dated 06/07/21,<br>#2] came to me and stated "I<br>cause she came out to ask<br>esident #5] up I went into the<br>and he was mad and hitting<br>her grab his arm and swat<br>her to leave and I would<br>CNA #2] and asked what |  |   |                 |  |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE A. BUILDING: _  | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED  |             |
|---|---|---|---------------------|--|-------------|
|   |   |   |                     |  | С           |
|   |   | NH2407  | B. WING             |  | 07/01/2021  |
| NAME OF D   | ROVIDER OR SUPPLIER   |   | DRESS, CITY, STA    | TE ZIR CODE  |             |
| NAME OF F   | ROVIDER OR SUFFLIER   |   | TH OAKWOOD F        |  |             |
| THE COM   | MONS  | ENID, OK  |                     | TOAD   |             |
| (V4) ID   | SUMMARY STA   | ATEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF CORRECTION  | (Y5)        |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETE |
| LL067   | Continued From page   | : 15  | LL067               |  |             |
|   |   | was just playing and I would us told by nurse to stay out of  |                     |  |             |
|   | documented, "[residesided [sic] to get his then uncovered him swas getting him dress his pull-up on the [sic] after that I took his hoready to put his arm is went to put his head in the shirt down. tried to si on leg to Push Leg in have my other hand a him sit up. then holle stand him to finish ge was fighting me. I wa [sic] him down to resu [CMA #2] came in the hold him up. then told the [sic] she would ge abusing him. I Left th room. then the nurse her no i was patting h down. [LPN #2] told is until told other wise"  An investigative summ "Who isthe reported #2]What happened. yanking on Residents legWhat was done to | e room and went the Breakask me if i hit him I told im to try come [sic] him me not go around him again. " mary, undated, documented, ed victim[resident I perpetrator[CNAAllegation that CNA was |                     |  |             |
|   | around the resident u   | ntil further notice by the then was suspended and   |                     |  |             |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE C   | ONSTRUCTION         |   | E SURVEY<br>PLETED              |                          |
|--|---|---|---------------------|---|---------------------------------|--------------------------|
|  |   | NH2407  | B. WING             |   | 07                              | C<br>7/ <b>01/2021</b>   |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE | , ZIP CODE  | ,                               |                          |
|  |   |   | ITH OAKWOOD RO      | •   |                                 |                          |
| THE COM  | MONS  | ENID, O   | K 73706             |   |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067  | the incident foreseed of being combative to deliveredWhen did happen06/07/21, [I supervisory/manage about the incident[  A final state report, of "A skin sweep was by two nurses with n Accused perpetrator 06/07/2021 pending 06/08/2021 she was the Administrator. Sor what could be con also completed a Re Understanding Demoperpetrator was allow 06/08/2021"  CNA #2's time sheet documented she wor a.m. to 10:04 a.m., a | story of the residentWas ableResident has a history of staff when cares are the incident 7:30 a.m.]When was facility ment staff first contacted 10:00 a.m.]"  lated 06/08/21, documented, completed on the resident of injuries notedThe was suspended on an investigation. On counseled by the DON and the received verbal education asidered to be abuse. She lias Training entitled entia. The accused eved to return to work on the complete of the country of the c | LL067               |   |                                 |                          |
|  | The facility had docu<br>unsubstantiated evel<br>witness, and failed to   | mented the allegation was<br>n through there was a<br>o complete a thorough<br>viewing other staff members  |                     |   |                                 |                          |
|  | to describe her inves<br>she would complete<br>and suspend staff, to<br>staff on the hall that<br>complete safe surve   | B p.m., the DON was asked stigation process. She stated an incident report, remove ake statements from other the incident occurred and ys on cognitive residents on a lt the incident occurred. She   |                     |   |                                 |                          |

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|               | FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:   |  | (X3) DATE SURVEY<br>COMPLETED |  |                 |
|---------------|--|--|-------------------------------|--|-----------------|
|               |  |  | A. BOILDING.                  |  |                 |
|               |  | NH2407   | B. WING                       |  | C<br>07/01/2021 |
| NAME OF P     | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STA              | TE ZIP CODE  |                 |
| NAME OF T     | NOVIDEN ON GOLT EIEN   |  | 'H OAKWOOD I                  |  |                 |
| THE COM       | MONS   | ENID, OK   |                               | (OAD   |                 |
| (X4) ID       | SUMMARY STA  | ATEMENT OF DEFICIENCIES  | ID                            | PROVIDER'S PLAN OF CORRECTION  | N (X5)          |
| PREFIX<br>TAG | ,  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                 | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE     |
| LL067         | Continued From page  | : 17   | LL067                         |  |                 |
|               | was asked if staff wor stated not always. She considered interviewing on other halls. She stated on 06/07/21 at when the investigation stated late on 06/07/21 thorough investigation stated, "I feel it was the resident was assed delayed injury. She stated lunch and when she in suspended and sent hashe worked on 06/08/here at 8:30 a.m. to me Relias training then rewas asked what discipreceived. She stated about dementia, she was asked what corresplace to prevent further residents. She stated about dementia, she was asked what corresplace to prevent further place to prevent further place to prevent further esidents. She stated the DON stated she can she called the CN acknowledged staff dithe incident in a timely LPN #2 did not report immediately and as a work with other reside and a half to two and | ked the same hall. She he was asked if she hig other staff and residents hated she has interviewed her residents. She was tigation was started. She higher staff and residents hated she has interviewed her residents. She was tigation was started. She higher staff and has asked higher was asked higher was asked if a higher was conducted. She horough." She was asked if higher has asked if higher was asked when higher was home. She was home. She was asked when higher was home. She was asked when higher was home. She holinary actions CNA #2 higher was home. She holinary actions were put in higher was home. He was home has home has home has home has home has home has home. He door open has home. He was has he was home has home. He was home has he was home has home. He was home has he was home has home. He was home has he |                               |  |                 |
|               | was asked what disciple received. She stated about dementia, she wand two and a half how was asked what corresplace to prevent further residents. She stated the DON stated she happened because C and she called the CN acknowledged staff dithe incident in a timely   | she watched Relias video was suspended on the 7th urs on the 8th. The DON ective actions were put in er abuse and protect the I there were no changes. didn't feel the allegation NA #2 left the door open MA for help. She d not notify DON or ADM of y manner.   |                               |  |                 |
|               | immediately and as a<br>work with other reside<br>and a half to two and<br>investigation was not   | result, CNA #2 continued to<br>ents for approximately one<br>a half hours. A thorough  |                               |  |                 |

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| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD ENID, OK 7306   (A4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX TAG  CROULATORY OR LSC IDENTIFYING INFORMATION)  LL067  LL067  CROTHING HE FROPPRIATE  LL067  The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a through investigation into the allegations abuse. The facility further failed to develope and implement and was policy for protecting residents from abuse.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) und pain.  A time record for RN #2, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, " She than [sic] began saying that she was raped by 50 females every 30 minutes Staff is not to go in her room by themselves. This was reported to administration per policy"  On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility.   | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CO   |                    |  | E SURVEY<br>PLETED                |          |
|---|--|---|--|--------------------|--|-----------------------------------|----------|
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS  301 SOUTH OAKWOOD ROAD ENID, OK 73706  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY)  LL067  LL067  Continued From page 18  It is unknown if other residents had been involved.  The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.  A time record for RN #2, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, "She than Isic) began saying that she was raped by 50 females every 30 minutesStaff is not to go in her room by themselves. This was reported to administration per policy"  On 06/28/21 at 5:20 a.m., two police officers were |  |   | NH2407   | B. WING            |  | 07                                |          |
| THE COMMONS  SUMMARY STATEMENT OF DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  LL067  Continued From page 18  It is unknown if other residents had been involved.  The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse.  4. Resident #8 had diagnoses which included pressure ulter to the sacrum requiring a wound vacuum (vac) and pain.  A time record for RN #2, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, "She than [sic] began saying that she was raped by 50 females every 30 minutesStaff is not tog oin her room by themselves. This was reported to administration per policy"  On 06/28/21 at 5:20 a.m., two police officers were   | NAME OF P  | ROVIDER OR SUPPLIER   |  | ADDRESS CITY STATE | ZIP CODE                                   | , ,                               |          |
| INCLUDED SUMMARY STATEMENT OF DEFICIENCIES  ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  LL067  COntinued From page 18  It is unknown if other residents had been involved.  The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement and abuse policy for protecting residents from abuse.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.  A time record for RN #2, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, "She than [sic] began saying that she was raped by 50 females every 30 minutesStaff is not to go in her room by themselves. This was reported to administration per policy"  On 06/28/21 at 5:20 a.m., two police officers were   |  |   |  |                    |  |                                   |          |
| PREFIX TAG  LLO67  LLO67  Continued From page 18  it is unknown if other residents had been involved.  The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement and abuse policy for protecting residents from abuse.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.  A time record for RN #2, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, "She than [sic] began saying that she was raped by 50 females every 30 minutesStaff is not to go in her room by themselves. This was reported to administration per policy"  On 06/28/21 at 5:20 a.m., two police officers were   | THE COM  | IMONS   | ENID, O  | K 73706            |  |                                   |          |
| it is unknown if other residents had been involved.  The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.  A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.  A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, "She than [sic] began saying that she was raped by 50 females every 30 minutesStaff is not to go in her room by themselves. This was reported to administration per policy"  On 06/28/21 at 5:20 a.m., two police officers were   | PREFIX   | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL   | PREFIX             | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T | TION SHOULD BE<br>THE APPROPRIATE | COMPLETE |
| When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."  At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send  | LL067  | it is unknown if other involved.  The facility failed to cabuse policy and proaccurate a thorough allegations abuse. To develope and implement protecting residents of the vacuum (vac) and para time record for RN documented she wor a.m.  A time record for CN documented she wor a.m.  A time record for CN documented she wor a.m.  A progress note, date documented, "She she was raped by 50 minutesStaff is not themselves. This was per policy"  On 06/28/21 at 5:20 a observed to be at the When approached, the a call that a resident They were asked whe call. One stated, "Abust At 5:25 a.m., the admetalk to you guys." She | levelope and implement and cedure that allowed fo an investigation into the he facility further failed to nent an abuse policy for from abuse.  diagnoses which included sacrum requiring a wound in.  #2, dated 06/27/21, ked from 5:33 p.m. to 5:39  A #5, dated 06/27/21, ked from 10:01 p.m. to 5:39  ed 06/28/21 at 4:23 a.m., than [sic] began saying that females every 30 to go in her room by a reported to administration  a.m., two police officers were a front door to the facility. They stated they had received the sout five minutes ago."  ininistrator stated, "I need to se stated, "We have a crazy in the facility have a crazy in the stated, "We have a crazy in the facility have a crazy in the stated, "I need to se stated, "We have a crazy in the facility have a crazy in the stated, "I need to se stated, "We have a crazy in the facility have a crazy in the stated, "I need to se stated, "We have a crazy in the facility have a crazy in the stated, "I need to se stated, "We have a crazy in the facility have a crazy in the stated, "I need to see stated, "We have a crazy in the facility have a crazy in the stated, "We have a crazy in the facility have a crazy in the f | LL067              |  |                                   |          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE C   |                     | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|---|---|---------------------|---|-----------------|
|   |   |   | A. BUILDING:        |   |                 |
|   |   | NH2407  | B. WING             |   | C<br>07/01/2021 |
| NAME OF F   | ROVIDER OR SUPPLIER   | STREET AL   | ODRESS, CITY, STATE | E, ZIP CODE   |                 |
| THE COM   | IMONS   |   | TH OAKWOOD RO       | DAD   |                 |
|   | 1   | ENID, OK  | 73706               |   |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLÉTE   |
| LL067   | Continued From page   | e 19  | LL067               |   |                 |
|   | documented, "Final of Abuse/Mistreatmer IncidentResident m being raped by 50 pe was also saying we w when staff CMA gave [signs/symptoms] of p day and final reports, of the investigation\$  A report summary, da completion 06/28/21 a "Who is/are the rep woman and 50 of the happenedAccusation bugsWhat was donfrom further harmStroom 2 at a timeWhof the incidentNotifithe resident's current statusAssessment of 06/28/21When was supervisor/managem about the incident1  A statement from RN "2305-2315 [11:05 began saying that the The bed was checked sign of bugs. She that she was raped. She allegations. She said woman and there is 5 She cannot really degoing in her room with | akes allegation that she was ople every 30 minutes. She were trying to poison her her ultramNo S/S obysical rape notedFor 5 please include a summary See attached  It e and time of report at 5:10 p.m., documented, orted perpetrator(s)A mWhat on of Rape and bed to protect the resident(s) aff was to always go in last was done upon discovery ed AdministratorWhat is physical done at 5PM facility ent staff first contacted 1:47 PM [06/27/21]"  #2 documented, o.m. to 11:15 p.m.] Resident are was bed bugs in her bed. If by 2 staff and found no an [sic] began saying that the seen yelling these that the rapest [sic] is a sign of them every 5 minutes. Scribe themStaff has been in 2 people and then after tration we have been going |                     |   |                 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED   |                     |  |                 |
|--|---|---|---------------------|--|-----------------|
|  |   |   | A. BUILDING: _      |  |                 |
|  |   | NH2407  | B. WING             |  | C<br>07/01/2021 |
|  |   |   |                     |  | 1 01/01/2021    |
| NAME OF P  | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STAT  | ,  |                 |
| THE COM  | MONS  | 301 SOU<br>ENID, OF   | TH OAKWOOD R        | COAD   |                 |
| (V4) ID  | SLIMMARY ST.  | ATEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF CORRECT   | ION (VE)        |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE  |
| LL067  | Continued From page   | e 20  | LL067               |  |                 |
|  | A statement from CN. 12:32 p.m., documen #8] started yellingS yelling rape. She said everyone has been rabeen raped every 30  A statement, dated 00 documented, "Reside abused and raped report A statement, dated 00 documented, "On 6 [resident #8's room not Rape multiple times a coming"   | A #5, dated 06/28/21 at ted, "At 11:14 pm [Resident hortly after she started d she was raped and that aped. She said that she has minutes by 50 people"  6/28/21, from CNA #7, ent stated she was being peatedly"  6/28/21, from CMA #5  -28-2021, resident in RM number] has been yelling and saying the police are  |                     |  |                 |
|  | nurse last night at 11: resident's wound vac was observed to be re from the charge nurse when the nurse went resident alleged rape the nurse had informe to go in there alone. told the nurse to go a get a description of w The nurse told the AD female rapist and 50 The charge nurse told "looks like us."  The ADM was asked with the resident last She stated she had in the family and physic resident. She stated | dessage from the charge and p.m. that stated the had alarmed. The ADM eading the text messages as we spoke. She stated in to check the alarm, the administrator stated ed her she had told staff not administrator stated she sk when it happened and that the person looked like. Of the resident reported a people every 30 minutes. If the ADM that the rapist how many staff had worked night. She stated, "Two." instructed the nurse to inform it an and to assess the the resident refused to be nistrator stated she told the |                     |  |                 |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 21 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE C   |                     | , , ,  | SURVEY<br>PLETED                 |                          |
|---|--|---|---------------------|--|----------------------------------|--------------------------|
|   |  |   | A. BoileBillo.      |  |                                  | С                        |
|   |  | NH2407  | B. WING             |  | 07                               | 7/01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, STATE | , ZIP CODE   |                                  |                          |
| TUE 001   |  | 301 SOU   | TH OAKWOOD RO       | AD   |                                  |                          |
| THE COM   | MONS   | ENID, OK  | 73706               |  |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TON SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067   | close to." She was a that had been working stated it was a CNA at The ADM was asked residents once she wallegation of rape. She with two,  On 06/25/21, an Imm situation was determing facility's failure to devabuse policy and procenvironement where be made without fear were protected/free of allegations were reported administrator and oth were throughly invest measuers were taken.  A staff member allegation was administrator and at the not conducted. The eduring the investigation against the nurse.  An allegation of staff resident #7 on 02/22/02/23/21, one day aft The residents were not member was allowed. | e someone you can't get sked who the two staff were g with the resident. She and an RN.  how she protected the as made aware of the ne stated, "I told her to go in ediate Jeopardy (IJ) ned to exist related to the relope and implement an allegations of abuse could of retailiation, residents of abuse and neglect, orted timely to the er agencies, allegations sigated and corrective in to prevent further abuse.  ed that LPN #3 had been beain medications to resident as not reported timely to the anorough investigation was imployee remained working on and no action was taekn being verbally abusive to 21 was not reported until er the allegation occured. ot protected as the staff | LL067               | DEFICIENC  | T)                               |                          |
|   |  | sed by staff witnessed and e facility failed to protect the   |                     |  |                                  |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 22 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE C  |                     |  | E SURVEY<br>PLETED             |                          |
|---|--|--|---------------------|--|--------------------------------|--------------------------|
|   |  | NH2407   | B. WING             |  | 0-                             | C<br>7/01/2021           |
|   |  | NH2407   |                     |  | 07                             | 70 17202 1               |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATE | E, ZIP CODE  |                                |                          |
| THE COM   | MONS   |  | TH OAKWOOD RO       | DAD  |                                |                          |
|   |  | ENID, OF   | K 73706             |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page  | 22   | LL067               |  |                                |                          |
|   |  | thorough investigation and measures to prevent further                         |                     |  |                                |                          |
|   |  |  |                     |  |                                |                          |
|   | Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going.  |  |                     |  |                                |                          |
|   |  | lahoma State Department of notified and verified the uation.                   |                     |  |                                |                          |
|   | At 11:28 a.m., the Adı notified of the IJ.   | ministrator (ADM) was  |                     |  |                                |                          |
|   | •  | ded plan of removal was<br>nistrator on 06/29/21 at 7:20<br>he following:      |                     |  |                                |                          |
|   | 2021 [By 8:00 p.m.] Misappropriation InveupdatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the serviced of the servic | completed by June 30th,<br>Abuse, Neglect,<br>stigation POLICY was             |                     |  |                                |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 23 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE (<br>A. BUILDING:  | CONSTRUCTION        |   | SURVEY<br>PLETED |                          |
|---|--|--|---------------------|---|------------------|--------------------------|
|   |  |  |                     |   |                  | С                        |
|   |  | NH2407   | B. WING             |   | 07               | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AL  | ODRESS, CITY, STAT  | E, ZIP CODE   |                  |                          |
| THE COM   | MONS   |  | TH OAKWOOD R        | OAD   |                  |                          |
|   | OUR MARK OF  | ENID, OK   |                     | DD0//DEDI0 D/ AV 05 00DD  |                  |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE         | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page  | 23   | LL067               |   |                  |                          |
|   | 06/28/21 [staff name   | to further consideration on deleted] was terminated.  3] will be terminated on   |                     |   |                  |                          |
|   | the INCIDENT RESP and includes the Adm Administrator, DON, A Center Resident serv administrator or design Director any allegation scheduled monthly material including screening, protection 106/30/21 with advantage and always protect our response team will material respond to allegations investigation has been | ADON, and HealthCare ices Director. The gnee will report to Board of n of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ng, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and is to ensure all thorough n completed." |                     |   |                  |                          |
|   | were interviewed and information related to administrative staff w   | Ns, one RN and three CMAs able to state accurate abuse and neglect and five ere interviewed and were information related to  |                     |   |                  |                          |
|   | of 06/30/21 at 5:10 p.<br>plan of removal and t<br>had been implemente   | rdy deficiency was lifted as<br>m. when all elements of the<br>he amended plan of removal<br>ed. The deficient practice<br>f actual harm at a pattern.   |                     |   |                  |                          |
|   | and staff interviews, i  | n, record review and resident<br>t was determined the facility<br>implement a policy and<br>by not:  |                     |   |                  |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 24 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED |   |  |                     |  |          |                          |
|---|---|--|---------------------|--|----------|--------------------------|
| 7.1.12 . 2.1.1  |   | .52.11   | A. BUILDING:        |  |          |                          |
|   |   |  | B. WING             |  | <b>I</b> | C                        |
|   |   | NH2407   | B. WING             |  | 07/      | /01/2021                 |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREETA  | DDRESS, CITY, STATE | E, ZIP CODE  |          |                          |
| THE COM   | MONS  | 301 SOU  | TH OAKWOOD RO       | DAD  |          |                          |
| 1112 00111  |   | ENID, O  | C 73706             |  |          |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page   | e 24   | LL067               |  |          |                          |
|   | ~ reporting abuse all   | egations timely,   |                     |  |          |                          |
|   | ~ conducting thoroug  | gh investigations,   |                     |  |          |                          |
|   | ~ protecting the resid  | dents,   |                     |  |          |                          |
|   | ~ implementing corre  | ective measures and  |                     |  |          |                          |
|   | <ul> <li>ensuring staff were<br/>actions for six [#1, 5,<br/>sampled residents re</li> </ul>  | - · · ·  |                     |  |          |                          |
|   | The facility identified facility.   | 95 residents resided in the  |                     |  |          |                          |
|   | Findings:   |  |                     |  |          |                          |
|   | preventabuse byF adverse action when report any genuine or regardingabuseTI retaliation, in any form making a report, com faithAbuse & Negle ABUSE OR NEGLECO MUST BE REPORTE IMMEDIATELYFAIL OR NEGLECT, EVEN NEGLECT, LEAVES THE SITUATIONBut Commons will not, in or harassing behavior violation of this policy including termination. and/or harassment: | Company actively works to Protecting employeesfrom they do the right thing and oncern he Company strictly prohibits n, against any individual plaint, or inquiry in good ct PolicyNO FORM OF CT IS TOLERATED AND |                     |  |          |                          |
|   |   | ımiliatingShouting, raising<br>in publicTelephone Calls &  |                     |  |          |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 25 of 227

Oklahoma State Department of Health

|               | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                  | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|---------------|---|---|------------------|---|-------------------------------|
|               |   |   | A. BUILDING: _   |   |                               |
|               |   |   | B WING           |   | C                             |
|               |   | NH2407  | B. WING          |   | 07/01/2021                    |
| NAME OF P     | ROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, STA | TE, ZIP CODE  |                               |
|               |   | 301 SOU   | TH OAKWOOD F     | ROAD  |                               |
| THE COM       | MONS  | ENID, OK  | 73706            |   |                               |
| (X4) ID       | SUMMARY ST  | ATEMENT OF DEFICIENCIES   | ID               | PROVIDER'S PLAN OF CORRECTION   | N (X5)                        |
| PRÉFIX<br>TAG | ,   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE COMPLETE                 |
| LL067         | Continued From page   | 25  | LL067            |   |                               |
| LLUO/         | Cell PhonesCell phetime onlyCode of Code ProceduresViolation rulesmay result in cup to and including diabuse of the residents or mental abuse by of MediaEmployees monfidentialabouton disparage any performance of the policy, date "Reporting Requirement reported immediately and to other officials is law. Allegations that reported within 2 hours be thoroughly investig further potential abus progressappropriate including report to the boardPreventionIt Commons that each mabuse, neglectAll faupon first employment thereafter, regarding. abuseImmediately abuse, neglect or mis supervisorThe superphone of the ADMINIS DONSuspected or also be reported to restate agencies, law enfamilies, and/or reside subject of abuse shald discussedInvestigat for, treat and PROTE | one use is limited to break onductDisciplinary as of any of these orrective action being taken, schargePhysical or mental is or failure to report physical thersSocial aust not post clientsEmployees should arsonbased ondisability"  and 12/08/2020, documented, entsallegations shall be to the administrator, DON in accordance with State involve abusemust be a smiller to the investigation is in a cation must be taken a papropriate licensing a spropriate licensing a spropriate licensing a significant will be free from a cility staff will be in-serviced at, and at least annuallyneglect or report any suspicion of a treatment to your immediate envisor WILL CALL the CELL STRATOR [admin], then the substantiated cases must spective agencies such as inforcement, physician; ent responsible party. The libe routinely and openly tionProcedure1stCare CT the resident-DON, | LLU6/            |   |                               |
|               | assessment immedia  | ervisor should do a medical<br>telydocumenting any injury   |                  |   |                               |
|               | in detailTake a state   | ement from the  |                  |   |                               |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 26 of 227

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED   |      |                          |
|---|--|--|---------------------|---|------|--------------------------|
|   |  |  | A. BUILDING         |   |      |                          |
|   |  | NH2407   | B. WING             |   | 07/0 | 1/2021                   |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |      |                          |
| THE COM   | MONS   | 301 SOUTH<br>ENID, OK  | I OAKWOOD F         | ROAD  |      |                          |
|   | ·  |  |                     | DDOWDEDIO DI AN OF CODDECTIO  | .,   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ALEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE   | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page  | 26   | LL067               |   |      |                          |
|   |  | e the perpetrator3rd<br>he Administrator, then DON   |                     |   |      |                          |
|   | Resident #9 had d<br>chronic pain and oste   | iagnoses which included oarthritis.  |                     |   |      |                          |
|   | A resident assessment documented the resident moderately impaired.   |  |                     |   |      |                          |
|   | "Resident is at risk muscle spasms and c syndromeResident  | chronic pain<br>will have pain<br>imely mannerAdminister   |                     |   |      |                          |
|   | "hydrocodone 7.5 mg<br>325 mg tablet (Norco  | ated 06/08/21, documented,<br>[milligrams]-acetaminophen<br>) give 1 tablet by oral route<br>ded FOR CHRONIC PAIN  |                     |   |      |                          |
|   | Tylenol 325 mg capsuroute every 6 hours a  | ule give 2 tablets by oral s needed for pain   |                     |   |      |                          |
|   | Ultram 50 mg tablet g<br>route every 6 hours a   | ive 1 tablet (50 mg) by oral<br>s needed for pain"   |                     |   |      |                          |
|   | 12:35 a.m., documen multiple occasions, ty in the morning after the [Resident #9] get up of ask for a pain pill. He Norco and rate his parabutt pain. As protoco request to the charge go to the resident to e | A #3, dated 06/26/21 at ted, "Generally everyday, on pically beginning first thing ne CNA has helped out of bed for the day, he will e will specifically ask for a nin at an 8 out of 10 for leg or I, as the CMA, I report the nurse, the charge nurse will evaluate the resident and e CMA, with guidance to |                     |   |      |                          |

Oklahoma State Department of Health

STATE FORM 6899 If continuation sheet 27 of 227 C7JI11

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ' '   | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|--|---|---------------------|---|-----------------|
|   |  |   | A. BUILDING: _      |   |                 |
|   |  | NH2407  | B. WING             |   | C<br>07/01/2021 |
|   |  | NH2407  |                     |   | 07/01/2021      |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STA   |   |                 |
| THE COM   | MONS   |   | TH OAKWOOD F        | ROAD  |                 |
|   | T  | ENID, OF  | 73706               |   |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE   |
| LL067   | Continued From page  | 27  | LL067               |   |                 |
|   | level of the pain that valocation of th [sic] pain [LPN #3], will deny the name], pain meds statedoesn't need a pain part smoke a cigarette, he he can go outside to a pain pill because he he on these occurances pain meds until some p.m. as reflected on the administration record.  An OSDH incident for documented, "[Residented]  | n. On many occurances, e resident, [Resident's titing 'He just got up, he ill' or 'He's going outside to is not hurting bad enough if smoke' or 'He can't have a nasn't eaten anything yet.', [Resident] won't receive times 10 a.m or as late a 2 he MAR [medication ]"  Tm, dated 06/26/21, ident #9]Allegations of .Description of ed Nurse not approving PRN dent asked for them. |                     |   |                 |
|   | 12:23 [did not docume documented, "Someti pills when it is not tim is scheduled [every] & offered Tylenol if Nord Safe surveys were confined to receiving particular of the allegand completed on 06, On 06/28/21 at 12:40 assistant administration conclusion of the investigation of the | imes resident asks for pain e as he had it earlier. Med B [hours] prn. Resident is co can't be given yet" Inducted with five residents. to the residents were not ain medications. The facility lation was unsubstantiated  |                     |   |                 |
|   |  | nurse had given Tylenol   |                     |   |                 |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE C A. BUILDING:  |                                      |   | SURVEY<br>PLETED                 |                          |
|---|---|---|--------------------------------------|---|----------------------------------|--------------------------|
|   |   | NH2407  | B. WING                              | C C   |                                  | _                        |
|   |   | NH2407  |                                      | 710 0005  | 07                               | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE<br>TH OAKWOOD RO |   |                                  |                          |
| THE COM   | IMONS   | ENID, OK  |                                      | <b>IAD</b>  |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067   | had administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it withheld the medicatic conclusion the allega She stated she went him about it. She stanurse's biggest cheer.  At 1:19 p.m., the ADM There were no questively sand thought related to staff withheld stated the executive surveys and thought members respect you make decisions regard that.  On 06/29/21 at 6:35 pif he was in pain. He right side, leg and known as in pain. He right side, leg and known as in pain. He right side, leg and known as asked if his Norce stated it was once. How he gets it. He womember was who with stated he was not good.  At 7:02 p.m., CMA #3 | medications as much as the as asked if there was times the resident had She stated she didn't think to had requested it. She was a documentation of when the and the CMA stated LPN #3 on, how did they come to the tion was unsubstantiated. To the resident and asked ted the resident is this releader.  If provided resident surveys one asked to the residents olding pain medications. She director had made the that the question "Do staff or requests and allow you to reding your care" covered one., the resident was asked stated he had pain in his the see. She stated he would one had been asked how he felt if the recombination of the requested it. The set was ever withheld. He was asked who the staff the held the medication. He ing to tell. | LL067                                |   |                                  |                          |
|   | Norco. She stated, "I   | arding LPN #3 withholding<br>Norco is what he asks for all<br>I, "It's upsetting to me cause  |                                      |   |                                  |                          |

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Oklahoma State Department of Health

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | CONSTRUCTION   | (X3) DATE SUR |                          |
|--------------------------|--|--|---------------------|--|---------------|--------------------------|
| ANDILAN                  | or dorate of the transfer of t | IDENTIFICATION NOWIDEN.  | A. BUILDING:        |  |               |                          |
|                          |  | NH2407   | B. WING             |  | 07/01/        | 2021                     |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE   |               |                          |
| THE COM                  | MONS   |  | I OAKWOOD I         | ROAD   |               |                          |
|                          |  | ENID, OK   | 73706               |  |               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE            | (X5)<br>COMPLETE<br>DATE |
| LL067                    | Continued From page  | e 29   | LL067               |  |               |                          |
|                          | when he asks for som<br>have to follow." She<br>give the same respon<br>statement. She state<br>their pain as they stat  | nething, I have protocol I<br>stated that LPN #3 would<br>uses CMA #3 had put in her<br>d she was taught to take<br>ted it. She stated LPN #3<br>nister Tylenol or Ultram  |                     |  |               |                          |
|                          | abuse policy and prod<br>accurate a thorough in<br>allegations abuse. The<br>develope and implem   | evelope and implement and cedure that allowed fo an nvestigation into the ne facility further failed to ent an abuse policy for rom abuse and negecit.   |                     |  |               |                          |
|                          | 2. Resident #7 was and diagnoses which incluance anxiety disorder.   | dmitted to the facility with uded convulsions and  |                     |  |               |                          |
|                          |  | ssessment, dated 02/18/21,<br>lent's cognition was severely  |                     |  |               |                          |
|                          | documented, "Incided Abuse/Mistreatment IncidentAdministrated allegation of verbal at from a staff member as is not on the schedule not be working until the investigated. Investigated and final reports, of the investigationa implemented to prevent attached for investigated.   | or was notified today of an ouse occurring on 02/22/21 against a nurse. The nurse e until Thursday. She will ne allegation has been gation is in progressFor 5 please include a summary and corrective measures ent recurrenceSee tion: Nurse yelled at aspended and counseled on rnout. Also gave her |                     |  |               |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 30 of 227

Oklahoma State Department of Health

|                          | FOF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE Co    | ONSTRUCTION   |                                   | E SURVEY<br>PLETED       |
|--------------------------|--|---|---------------------|---|-----------------------------------|--------------------------|
|                          |  |   | A. BOILDING.        |   |                                   | 0                        |
|                          |  | NH2407  | B. WING             |   | 07                                | C<br><b>7/01/2021</b>    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, STATE | ZIP CODE  |                                   |                          |
|                          |  |   | TH OAKWOOD RO       |   |                                   |                          |
| THE COM                  | MONS   | ENID, OK  |                     |   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO DEFICIENCE) | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067                    | Continued From page  | e 30  | LL067               |   |                                   |                          |
|                          |  | se was not reported to the next day after it occurred.  |                     |   |                                   |                          |
|                          | within two hours to th   | eport the allegation of abuse<br>e appropriate agencies such<br>te Department of Health                                   |                     |   |                                   |                          |
|                          | documented, "The da<br>spent a majority of the<br>hallway outside of [ar | y CMA #3, dated 02/23/21,<br>y of 2-22-21, [resident #7]<br>e day sitting in the North Hall<br>nother resident]s room. At |                     |   |                                   |                          |
|                          | himself in his wheelch   | [resident #7] wheeled nair up closer to the nurse's ed himself in his wheelchair care nurse's office.                     |                     |   |                                   |                          |
|                          | and yelled to [residen<br>here, you're not going                         | ge nurse, [LPN #3], stood up<br>it #7] "get the hell out of<br>g to sit up here while I'm                                 |                     |   |                                   |                          |
|                          | yelled at [LPN #3]. I  | did raise his hands and<br>do not know what he yelled<br>often hard to make out due                                       |                     |   |                                   |                          |
|                          | again "get the hell ou talk to me that way."                             | [LPN #3] then yelled at him<br>t of here, you're not going to<br>After this occurrence,                                   |                     |   |                                   |                          |
|                          | nurse's station area b   | himself away from the<br>back down the hall towards<br>occurrence, [CMA #4] was<br>de me and witnessed the                |                     |   |                                   |                          |
|                          | documented, "On Mo   | y CMA #4, dated 02/24/21,<br>nday February 22nd I [CMA  |                     |   |                                   |                          |
|                          | sitting at nurses station  | was on North Hall. I was<br>on [resident #7] the resident<br>ne Common Area by the  |                     |   |                                   |                          |
|                          | nurses station [LPN # around and go back h                               | f3] the nurse told him to turn<br>ne said he has rights She<br>ot gonna [sic] deal with you                               |                     |   |                                   |                          |
|                          | and he said he wante   |   |                     |   |                                   |                          |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE C     |  |                                    | E SURVEY<br>PLETED       |
|--------------------------|---|--|---------------------|--|------------------------------------|--------------------------|
|                          |   |  |                     |  |                                    | С                        |
|                          |   | NH2407   | B. WING             |  | 07                                 | //01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, STATE | , ZIP CODE   |                                    |                          |
| THE COM                  | MONS  | 301 SOU  | TH OAKWOOD RO       | )AD  |                                    |                          |
|                          |   | ENID, OK   | 73706               |  |                                    |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>ITHE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067                    | your [sic] not sitting u deal with your Ass. so Corner til [LPN #3] let of the evening"  A written statement by documented, "The otl getting something wh at [resident #7]. And [Resident #7] started #3] got louder and tol listen to it. Go to you Im sick of him acting A written statement by 5:00 p.m., documente [administrator (admin back [and] was told the against me for yelling Monday February 22r [approximately] [2:00 the man but suppose [admin] via the camer told I told male reside | said "I dont give a dam [sic] p here Im not gonna [sic] p [resident #7] sat in the ft he was very upset the rest  y CNA #3, dated 02/24/21, her day I was in the office en I heard [LPN #3] yelling telling him to go to his room. yelling back at her and [LPN d him she wasn't going to r room. [LPN #3] then said like this"  y LPN #3, dated 02/24/21 at ed, "Missed a call from )] [at] the Commons. Called here was an allegation [at] a male on North Hall on | LL067               |  |                                    |                          |
|                          | to sit in the area by w   | ound care Nurse's office as<br>yMay of raised my voice   |                     |  |                                    |                          |
|                          | "Who is/are the rep<br>#7]Who is/are the re<br>#3]Who witnessed to<br>[CNA #3], [CMA #4]<br>happenedResident.<br>sitting near the nurse<br>came down the hall at<br>leave the deskWhat  | was in his wheelchair<br>'s desk. [LPN #3] the nurse<br>nd started yelling at him to   |                     |  |                                    |                          |

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Oklahoma State Department of Health

|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                       | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |    |
|--------------------------|---|---|-----------------------|--|-------------------------------|----|
|                          |   |   | A. BUILDING: _        |  | _                             |    |
|                          |   | NH2407  | B. WING               |  | 07/01/2021                    |    |
| NAME OF D                |   |   |                       | TE 7/D 000E  | 1 0170112021                  |    |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | DRESS, CITY, STA      |  |                               |    |
| THE COM                  | MONS  | 301 SOU<br>ENID, OK   | TH OAKWOOD F<br>73706 | ROAD   |                               |    |
| (VA) ID                  | SLIMMARY ST.  | ATEMENT OF DEFICIENCIES   |                       | PROVIDER'S PLAN OF CORRECTION  | ON (VE)                       |    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE COMPLE                   | TE |
| LL067                    | Continued From page   | e 32  | LL067                 |  |                               |    |
| LL067                    | resident has had outh reason a staff member shoul this incident was not existed with the incident. When did to the incident with the incident | oreaks lately, but there is NO er should yell at a resident. d Never yell at resident, but foreseeableWhat does the n[resident #7] would not but when asked what he he just shrugged his the incident happenAround y] 22ndWhen was facility ment staff first contacted on Feb 23rd"  of Nursing complaint form, //21, documented, "Nurse's incident include MisconductYes: Patient f InvestigationLPN was the investigation and 2/26/2021. She received te up for raising her voice at inducting herself in a manner d standards. Her cility is being retained"  oeriod from 02/14/21 to d LPN #3 worked til 6:48 PN #3 worked approximately es after the abuse occurred. | LL067                 |  |                               |    |
|                          | not completed.  |   |                       |  |                               | ſ  |
|                          | to describe the incide 02/22/21 with residen  | • •   |                       |  |                               |    |

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| STATEMEN                 | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | CONSTRUCTION   | (X3) DATE<br>COMP                 | SURVEY<br>LETED          |
|--------------------------|---|---|---------------------|--|-----------------------------------|--------------------------|
|                          |   |   | A. BOILDING         |  |                                   | С                        |
|                          |   | NH2407  | B. WING             |  | <b>I</b>                          | 01/2021                  |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, STA    | TE, ZIP CODE   |                                   |                          |
| THE COM                  | MONS  | 301 SOUT  | H OAKWOOD F         | ROAD   |                                   |                          |
| THE COM                  | WICHS   | ENID, OK  | 73706               |  |                                   | _                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067                    | Continued From page   | e 33  | LL067               |  |                                   |                          |
|                          | took statements from and discussed the inc wife. She was asked 02/22/21. She stated asked when the incid stated she was notific was asked what the c was. She stated it will did it. She stated she write up. She was as tolerance for abuse. hand book is wrong." done to protect and p to other residents. Si anything else other the was asked who the stabuse to. She stated asked when the staff did they report timely asked if the staff who | d she reviewed the cameras, the witnesses and LPN #3 cident with the resident's when LPN #3 worked on I she didn't know. She was ent was reported. She ed on the following day. She cutcome of her investigation as substantiated that LPN #3 was suspended and had a sked if the facility had a zero She stated, "If I say yes, my She was asked what was revent this from happening the stated they didn't add than what was in place. She taff can report suspected I, "Any authority." She was had witnessed the abuse, She stated, "No." She was witnessed the abuse were orting timely. She stated, |                     |  |                                   |                          |
|                          | verbal abuse happen p.m. She stated "Yes continued to work after was asked if LPN #3 residents, how were the stated," They couldn't about it." She was as   | o.m., the DON was asked if ed on 02/22/21 around 2:00 s." She was asked if LPN #3 er. She stated, "Yes." She continued to work with the resident protected. She to be, because we didn't know sked, since the staff failed to lediately, were the residents d, "No."  |                     |  |                                   |                          |
|                          | after the incident. Sh<br>The staff members w   | if the resident was assessed e stated, "No."  ho witnessed the abuse did rt it. As a result, LPN #3   |                     |  |                                   |                          |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C     |  | (X3) DATE<br>COMP |                          |
|--------------------------|--|---|---------------------|--|-------------------|--------------------------|
|                          |  |   |                     |  |                   | С                        |
|                          |  | NH2407  | B. WING             |  | 07/               | 01/2021                  |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | , ZIP CODE   |                   |                          |
| THE COM                  | IMONS  | 301 SOU   | TH OAKWOOD RO       | DAD  |                   |                          |
|                          |  | ENID, OF  | K 73706             |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROFICENCY) | ULD BE            | (X5)<br>COMPLETE<br>DATE |
| LL067                    | Continued From page worked with the victin approximately four hore. The facility did not pure place to prevent abuse result, one of the with allegation of verbally. The facility substantiaterminated CMA #4 wemployed by the facil. The facility failed to drabuse policy and prodraccurate a thorough if allegations abuse. The develope and implement protecting residents from the facility residents from the facility residents from the facility resident and the facility decision making. An initial incident report documented, "Resident #5]Incident TypeA Abuse/MistreatmentIncidentReceived at towards a resident by | and other residents for ours and 48 minutes.  It any corrective measures in the from reoccurring. As a sesses [CMA #4] had an abusing a different resident. It allegation and while LPN #3 continued to be dity.  Evelope and implement and the dedure that allowed fo an analysis and investigation into the facility further failed to the ent an abuse policy for from abuse.  Idmitted to the facility with the ded dementia.  Seessment, dated 05/02/21, then's cognitive skills for was severely impaired.  For the form, dated 06/07/21, thent's involved[resident the facility of an allegation of abuse. | LL067               |  |                   |                          |
|                          | A written statement fr<br>06/07/21, documente<br>#2] asked me if I coul<br>yes just give me a se-<br>middle of taking care<br>I walked into [residen   |   |                     |  |                   |                          |

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| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION   | PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO    |   | · ,                               | E SURVEY<br>PLETED       |
|--|--|---------------------|---|-----------------------------------|--------------------------|
|  |  |                     |   |                                   | С                        |
|  | NH2407   | B. WING             |   | 07                                | //01/2021                |
| NAME OF PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STATE | , ZIP CODE  |                                   |                          |
| THE COMMONS  | 301 SOU  | TH OAKWOOD RO       | AD  |                                   |                          |
| THE COMMONS  | ENID, OF   | 73706               |   |                                   |                          |
| PREFIX (EACH DEFICIENCY MU   | MENT OF DEFICIENCIES<br>JST BE PRECEDED BY FULL<br>IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| documented, "[CMA #2] becaume to help get him [resideroom where she was and at her states she saw here at his left leg so I told here finish him, I went to [CNA happened she said I was never hurt anyone was to room"  A written statement from documented, "[resident desided [sic] to get him used then uncovered him start was getting him dressed. his pull-up on the [sic] the after that I took his hospit ready to put his arm in. to | apping at his left leg,-on r to stop doing him that what [and] just kind of e bed, she went to pull on old her to just leave that I I brought him out for Charge Nursewhat had PN #2] talked to [CNA way from direct care of en [sic] D.O.Naround PN #2] had talk to her had happened She told ut now she is [and] statement"  LPN #2, dated 06/07/21, came to me and stated "I have she came out to ask tent #5] up I went into the dine was mad and hitting r grab his arm and swat r to leave and I would A #2] and asked what is just playing and I would be bed by nurse to stay out of CNA #2, dated 06/07/21, the special paying and I would be guest playing | LL067               |   |                                   |                          |

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Oklahoma State Department of Health

| NAME OF PROVIDER OR SUPPLIER  A. BUILDING:  B. WING  O7/01/  | 1/2021                   |
|--|--------------------------|
| NH2407 B. WING 07/01/  | 1/2021                   |
| N12407 - 07/01/  | 1/2021                   |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |                          |
|  |                          |
| THE COMMONS 301 SOUTH OAKWOOD ROAD   |                          |
| ENID, OK 73706   |                          |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCY IDENTIFYING INFORMATION IDENTIFYING INFORM | (X5)<br>COMPLETE<br>DATE |
| LL067 Continued From page 36 LL067   |                          |
| him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting hisleg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw I was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurseask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise"  An investigative summary, undated, documented, "Who isthe reported victim[resident #5]who isreported perpetrator[CNA #2]What happenedAllegation that CNA was yanking on Residents arm and slapping his legWhat was done to protect the resident(s) from further harmStaff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending in vestigation by the DONWhat is the history of the residentWas the incident foreseeableResident has a history of being combative to staff when cares are deliveredWhen did the incident happen06/07/21, [7:30 a.m.]When was facility supervisory/management staff first contacted about the incident[10:00 a.m.]"  A final state report, dated 06/08/21, documented, "A skin sweep was completed on the resident by two nurses with no injuries notedThe Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She  |                          |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C A. BUILDING: |   |                              | E SURVEY<br>PLETED       |
|--------------------------|---|---|------------------------------|---|------------------------------|--------------------------|
|                          |   |   | A. BOILDING.                 |   |                              | 0                        |
|                          |   | NH2407  | B. WING                      |   | 07                           | C<br>7/ <b>01/2021</b>   |
|                          |   |   |                              |   | 1 07                         | 770 17202 1              |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE          | ,   |                              |                          |
| THE COM                  | MONS  |   | TH OAKWOOD RO                | OAD   |                              |                          |
|                          |   | ENID, OI  |                              |   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067                    | Continued From page   | e 37  | LL067                        |   |                              |                          |
|                          | Understanding Deme<br>perpetrator was allow<br>06/08/2021"  | entia. The accused<br>yed to return to work on  |                              |   |                              |                          |
|                          | documented she work a.m. to 10:04 a.m., ar  | dated 06/06/21 to 06/19/21,<br>ked on 06/07/21 from 6:30<br>nd from 10:36 a.m. to 11:37<br>from 8:27 a.m. to 1:27 p.m.,<br>o 2:32 p.m.  |                              |   |                              |                          |
|                          | unsubstantiated even witness, and failed to   | <del>-</del>  |                              |   |                              |                          |
|                          | to describe her investions she would complete a and suspend staff, ta staff on the hall that the complete safe survey the section of the hall was asked if staff work stated not always. Stock considered interviewing on other halls. She so ther staff but not other staff but not other staff but not other staff on 06/07/21 at when the investigation stated late on 06/07/2 thorough investigation stated, "I feel it was the | ng other staff and residents stated she has interviewed her residents. She was stigation was started. She at 10:00 a.m. She was asked in was completed. She an was conducted. She horough." She was asked if essed after incident for |                              |   |                              |                          |
|                          |   | CNA #2 had worked on<br>I she left at 10:04 a.m. for<br>returned, she was   |                              |   |                              |                          |

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|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | CONSTRUCTION  | (X3) DATE SUR<br>COMPLETE |                          |
|--------------------------|--|--|---------------------|---|---------------------------|--------------------------|
|                          |  |  | A. BOILDING         | A. BUILDING:  |                           |                          |
|                          |  | NH2407   | B. WING             |   | C<br>07/01/2              | 2021                     |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |                           |                          |
| THE COM                  | MONS   |  | I OAKWOOD I         | ROAD  |                           |                          |
|                          | OUR MARK OT  | ENID, OK   |                     |   |                           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                        | (X5)<br>COMPLETE<br>DATE |
| LL067                    | Continued From page  | 38   | LL067               |   |                           |                          |
|                          | suspended and sent is she worked on 06/08, here at 8:30 a.m. to no Relias training then rewas asked what discireceived. She stated about dementia, she and two and a half how was asked what correplace to prevent furth residents. She stated The DON stated she happened because C and she called the CN | nome. She was asked when (21. She stated she was neet with DON and watch eturned to the floor. She plinary actions CNA #2 she watched Relias video was suspended on the 7th ours on the 8th. The DON ective actions were put in er abuse and protect the dithere were no changes. didn't feel the allegation NA #2 left the door open MA for help. She id not notify DON or ADM of |                     |   |                           |                          |
|                          | work with other reside<br>and a half to two and<br>investigation was not   | result, CNA #2 continued to<br>ents for approximately one<br>a half hours. A thorough<br>completed by not<br>ff and residents. As a result,  |                     |   |                           |                          |
|                          | abuse policy and prod<br>accurate a thorough i<br>allegations abuse. The   | ne facility further failed to<br>ent an abuse policy for   |                     |   |                           |                          |
|                          |  | iagnoses which included<br>sacrum requiring a wound<br>in.   |                     |   |                           |                          |
|                          | A time record for RN documented she work   | #2, dated 06/27/21,<br>ked from 5:33 p.m. to 5:39  |                     |   |                           |                          |

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|                          | FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|---------------------|--|-------------------------------|
|                          |  | NH2407   | B. WING             |  | C<br>07/01/2021               |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STA   | TE, ZIP CODE   |                               |
|                          |  |  | TH OAKWOOD F        |  |                               |
| THE COM                  | MONS   | ENID, OF   | 73706               |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE                   |
| LL067                    | Continued From page  | 39   | LL067               |  |                               |
|                          | a.m.  A progress note, date documented, "She is she was raped by 50 minutesStaff is not is themselves. This was per policy"  On 06/28/21 at 5:20 a observed to be at the When approached, the a call that a resident is They were asked whe call. One stated, "About At 5:25 a.m., the administration of the control of the call that a resident is the call. One stated, "About At 5:25 a.m., the administration of the call that a resident is the call.   | d 06/28/21 at 4:23 a.m., than [sic] began saying that females every 30 to go in her room by reported to administration  a.m., two police officers were front door to the facility. ey stated they had received had been sexually abused. en they had received the but five minutes ago." |                     |  |                               |
|                          |  | e stated, "We have a crazy<br>as raped and I didn't send   |                     |  |                               |
|                          | documented, "Final of Abuse/Mistreatmer IncidentResident material being raped by 50 perwas also saying we with when staff CMA gave [signs/symptoms] of particular processing the staff control of the staff control of particular processing the staff control of particular processi | akes allegation that she was ople every 30 minutes. She were trying to poison her her ultramNo S/S ohysical rape notedFor 5 please include a summary   |                     |  |                               |
|                          |  | at 5:10 p.m., documented, orted perpetrator(s)AmWhat   |                     |  |                               |

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STATE FORM 6899 C7JI11 If continuation sheet 40 of 227

Oklahoma State Department of Health

|                          | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S ID PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:  A. BUILDING:   |   |                     |   |      |                          |
|--------------------------|---|---|---------------------|---|------|--------------------------|
|                          |   |   |                     |   |      | ;                        |
|                          |   | NH2407  | B. WING             |   | 07/0 | 1/2021                   |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |      |                          |
| THE COM                  | MONS  |   | OAKWOOD F           | ROAD  |      |                          |
|                          |   | ENID, OK  | 73706               |   |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE   | (X5)<br>COMPLETE<br>DATE |
| LL067                    | Continued From page   | 40  | LL067               |   |      |                          |
| LL067                    | bugsWhat was done from further harmSt room 2 at a timeWh of the incidentNotific the resident's current statusAssessment of 06/28/21When was supervisor/manageme about the incident17  A statement from RN "2305-2315 [11:05 pt began saying that the The bed was checked sign of bugs. She that she was raped. She said woman and there is 5 She cannot really designing in her room with being told by Administin with 2 Licensed nutA statement from CN/12:32 p.m., document #8] started yellingSl yelling rape. She said everyone has been rabeen raped every 30.  A statement, dated 06 documented, "Reside abused and raped rep. | e to protect the resident(s) aff was to always go in at was done upon discovery ed AdministratorWhat is physical done at 5PM facility ent staff first contacted 1:47 PM [06/27/21]"  #2 documented, o.m. to 11:15 p.m.] Resident re was bed bugs in her bed. I by 2 staff and found no in [sic] began saying that has been yelling these that the rapest [sic] is a 0 of them every 5 minutes. cribe them Staff has been in 2 people and then after tration we have been going rese"  A #5, dated 06/28/21 at red, "At 11:14 pm [Resident mortly after she started if she was raped and that inped. She said that she has minutes by 50 people"  6/28/21, from CNA #7, int stated she was being peatedly" | LL067               |   |      |                          |
|                          | [resident #8's room nu  | umber] has been yelling nd saying the police are  |                     |   |      |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION   |                      | (X3) DATE SURVEY<br>COMPLETED   |      |                  |
|---|---|--|----------------------|---|------|------------------|
| ANDILAN   | or connection   | IDENTIFICATION NOMBER.   | A. BUILDING: _       |   |      |                  |
|   |   | NH2407   | B. WING              |   | 07/0 | )<br>1/2021      |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD   | DRESS, CITY, STA     | TE, ZIP CODE  |      |                  |
| THE COM   | MONS  | 301 SOUTI<br>ENID, OK  | H OAKWOOD F<br>73706 | ROAD  |      |                  |
| (X4) ID   | SUMMARY ST  | ATEMENT OF DEFICIENCIES  | ID                   | PROVIDER'S PLAN OF CORRECTIO  | N    | (X5)             |
| PREFIX<br>TAG   | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG        | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | COMPLETE<br>DATE |
| LL067   | Continued From page   | e 41   | LL067                |   |      |                  |
|   | On 06/28/21 at 6:27 a had received a text murse last night at 11 resident's wound vac was observed to be not from the charge nurse when the nurse went resident alleged rape the nurse had informe to go in there alone. told the nurse to go a get a description of worth the nurse told the AE female rapist and 50 | a.m., the ADM stated she dessage from the charge 114 p.m. that stated the had alarmed. The ADM deading the text messages as we spoke. She stated in to check the alarm, the administrator stated ded her she had told staff not The administrator stated she sk when it happened and that the person looked like. DM the resident reported a people every 30 minutes. It the ADM that the rapist |                      |   |      |                  |
|   | with the resident last She stated she had in the family and physic resident. She stated assessed. The admin nurse, "You can't rape close to." She was a that had been working stated it was a CNA at The ADM was asked residents once she w   | the resident refused to be istrator stated she told the e someone you can't get sked who the two staff were g with the resident. She and an RN.  how she protected the as made aware of the  |                      |   |      |                  |
|   | with two, always two. facility policy was for was an allegation of a find the policy." She reading it. She stated them, suspend." She two staff had been suat the time." She stated   | ne stated, "I told her to go in " She was asked what the protecting residents if there abuse. She stated, "Let me located the policy and began d, "Immediately remove was asked if either of the spended. She stated, "Not ted, "I came and did it later." time she suspended them.  |                      |   |      |                  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | . ,   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|--|---|-------------------------------|--------------------------|
|   |  |   |  |   | С                             |                          |
|   |  | NH2407  | B. WING                                  |   | 07/01                         | /2021                    |
| NAME OF PI  | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA                          | TE, ZIP CODE  |                               |                          |
| THE COM   | MONS   | 301 SOUTH<br>ENID, OK   | I OAKWOOD F<br>73706                     | ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL067   | She was asked if her employees for allegat followed. She stated, On 06/29/21 at 11:30 regarding resident #8 reviewed with the AD her report on the staff. Reviewed with the AD 06/28/21, where she texted her that the resperpetrators as "looks investigative report do unable to give a desc "Yes", referring to the information. She was concerned about the "What does the report interview from yesterd reported to her the de "looks like us" and the resident was unable to There was no respon. The two employees refacility all night after the resident identifying the who raped her.  The facility failed to dabuse policy and producting residents for the state of the protecting residents for the state of the stat | policy for suspending ions of abuse had been "No."  a.m., the investigation allegation of rape was M. She stated she based is statements.  OM her interview from reported the charge nurse sident described the slike us" and that the ocumented the resident was ription. The ADM stated, discrepancies in s asked if she was discrepancies. She stated, at say." Reviewed her day that she stated the nurse escription the resident stated to describe the perpetrator. See given.  The ADM stated, and the perpetrator is a saked if she was discrepancies. She stated, are report documented the objective of the perpetrator. See given.  The ADM stated is a saked if she was discrepancies. She stated the nurse rescription the resident stated the report documented the objective of the perpetrator. See given.  The ADM stated is a saked if she was discrepancies in the perpetrator is a saked if she was discrepancies. She stated the nurse rescription the resident was ription. | LL067                                    | DEL ROILING I)  |                               |                          |
|   | Huntington's disease.  |   |  |   |                               |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CO<br>A. BUILDING:   |                     |  | E SURVEY<br>PLETED                |                          |
|---|---|--|---------------------|--|-----------------------------------|--------------------------|
|   |   |  |                     |  | С                                 |                          |
|   |   | NH2407   | B. WING             |  | 07                                | 7/01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET   | DDRESS, CITY, STATE | , ZIP CODE   |                                   |                          |
| THE COM   | MONS  | 301 SOL  | ITH OAKWOOD RO      | AD   |                                   |                          |
| THE COM   | WONS  | ENID, O  | K 73706             |  |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL067   | Continued From page   | e 43   | LL067               |  |                                   |                          |
|   |   | dent's cognition was intact.   |                     |  |                                   |                          |
|   | A time record, dated<br>#1 worked from 5:42   | 03/21/21, documented LPN<br>a.m. to 3:21 p.m.  |                     |  |                                   |                          |
|   | A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back"   |  |                     |  |                                   |                          |
|   | documented, "Alleg<br>MistreatmentDescr<br>IncidentAdministrat<br>director that activity a<br>statement, that she o<br>F****** Christ, [Resid<br>notified he had fallen<br>The nurse is suspend<br>complete" A facsin | iption of for was notified by Activity hide reported to her in a liverheard a nurse say "Jesus lent #6] really? when she was liverheard investigation is hile (fax) cover sheet, ort was sent to the OSDH on |                     |  |                                   |                          |
|   |   | entation in the resident's<br>alleged abuse against the  |                     |  |                                   |                          |
|   |   | port the allegation of abuse<br>te Department of Health<br>o hours.  |                     |  |                                   |                          |
|   | A time record for LPN<br>worked on 03/23/21 f   | I #1 documented she<br>from 5:42 a.m. to 2:34 p.m.   |                     |  |                                   |                          |
|   | at 6:38 p.m., docume day and final reports,   | faxed to OSDH on 03/23/21<br>ented the followingFor 5<br>please include a summary<br>Face Sheet attached,<br>d"  |                     |  |                                   |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED  |               |
|---|--|--|---------------------|--|---------------|
|   |  | 7. BOILBING.   |                     | С  |               |
|   |  | NH2407   | B. WING             |  | 07/01/2021    |
| NAME OF PR  | ROVIDER OR SUPPLIER  | STREET AL  | DRESS, CITY, STA    | TE, ZIP CODE   |               |
|   |  |  | TH OAKWOOD F        |  |               |
| THE COM   | WONS   | ENID, OK   | 73706               |  |               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | D BE COMPLETE |
| LL067   | Continued From page  | <del>2</del> 44  | LL067               |  |               |
|   | on 03/23/21. The folloasked:  1. Do you feel like whight, you get everythi 2. Have you heard stalanguage?  3. Has staff ever yelle 4. If you feel like your know who to talk to? No negative answers  LPN #1 reamained was verbal abuse had been invesitigation.  There were no written reporting staff member or other staff with the administrator document the staff member maked thers. She documented reported hearing the commender who had manadministrator document incident did not occur.  On 06/24/21 at 1:35 pwhen LPN #1 worked she worked til 3:21 p. did the LPN receive. She was asked when completed. She state completed, but the dostated there was confirmed to the confirmed there was confirmed to the stated t | orking after the allegation of en made and throughout the staff statements from the er, the perpetrator (LPN #1) investigation. The ented that she had spoken to king the allegation and three ented she spoke with resident the only person who comments was the staff de the allegation. The ented her conclusion was the ented her conclusion was the ented her conclusion was the ented the investigation had been ed the investigation was ocumentation was not. She elict between the activity aide is asked if LPN #1 had |                     |  |               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|----------------------------|---|-------------------------------|--|
|   |  | A. BUILDING:               |   |                               |  |
| NH24  | 07   | B. WING                    |   | C<br><b>07/01/2021</b>        |  |
| AME OF PROVIDER OR SUPPLIER   |  | RESS, CITY, STA            | TE ZIP CODE   | 0170172021                    |  |
|   |  | OAKWOOD F                  |   |                               |  |
| HE COMMONS  | ENID, OK   | 73706                      |   |                               |  |
| (X4) ID SUMMARY STATEMENT OF DI<br>PREFIX (EACH DEFICIENCY MUST BE PRE<br>TAG REGULATORY OR LSC IDENTIFYIN  | CEDED BY FULL  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETE                   |  |
| place to prevent reoccurrence and residents. She stated there were She was asked, how residents had protected if the LPN worked during investigation. She stated the comere-interviewed and had a discussion the allegation could not have occut asked if was reported timely. She not notified until the next day.  On 06/25/21 at 3:09 a.m., the actit asked if she recalled the incident She stated she did. She stated Licursed at the resident when she rethat he had fallen. She stated, LF "Jesus F*** Christ, [Resident]. Reasked who she had reported the instated she reported it to her superand that her supervisor was going administrator.  The facility failed to develope and abuse policy and procedure for reallegations timely to the administrator approrpaite agencies, that protect during an investigation, and thoro investigate an allegation of abuse 6. Resident #1 was admitted to the diagnoses which included Parkins A quarterly resident assessment, documented the resident's cognition impaired.  A state incident report form, dated documented, "ResidentInvolve #1]Incident TypeAllegations of Abuse/Mistreatment" | no changes. Ind been Ing the Inplainant was Ion about how Interest. She was Invity aide was In | LL067                      |   |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED   |               |
|---|--|---|-------------------|---|---------------|
|   |  |   | A. BUILDING: _    |   |               |
|   | D WING   |   |                   | С   |               |
|   |  | NH2407  | B. WING           |   | 07/01/2021    |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, STA | TE, ZIP CODE  |               |
|   |  | 301 SOU   | TH OAKWOOD F      | ROAD  |               |
| THE COM   | MONS   | ENID, OK  | 73706             |   |               |
| (X4) ID   | SUMMARY ST   | ATEMENT OF DEFICIENCIES   | ID                | PROVIDER'S PLAN OF CORRECTION   | DN (X5)       |
| PRÉFIX<br>TAG   | ,  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG     | (EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | O BE COMPLETE |
| LL067   | Continued From page  | e 46  | LL067             |   |               |
|   | A notification of nurse 06/12/21, documente employee terminated 06/12/2021ALLEGA ABUSEOn June 12 11:00 am a incident with member in which a Rinvolved. CNA #1 red shoe for her and she personal SnapChat sidoes your resident ever eason??" The captic laughing face emoji a was terminated for miviolation of our facility. On 06/23/21 at 8:59 awhen were the staff in phone use and social inserviced when they She was asked what media restrictions we anything about reside pictures. She stated cell phones in break in phone in resident are the staff were inserviced they had to wait for the updated policy. She measures were put in | e aide report, dated d, "CNA #1wasYestermination date ATIONS/FACTS OF , 2021 at approximately was reported by a staff esident [resident #1] was corded [resident #1] tying her posted the video on her tory with the caption "But wer tie your shoes for no on was followed by a nd heart emoji. [CNA #1] istreatment of a resident and or Social Media Policy"  a.m., the DON was asked inserviced related to cell media. She stated they are are hired during orientation. the cell phone and social re. She stated not to post ents, the facility and no staff were only to have their froom and not to have a cell as. The DON was asked if the cell phone in June but heir board's approval of the was asked if any corrective |                   |   |               |
|   | they weren't. On 06/24/21 at 2:00 r  | o.m., the DON was asked   |                   |   |               |
|   | what staff were interv   |   |                   |   |               |
|   |  | ated CMA #1. She stated   |                   |   |               |
|   | they did not interview working that same sh  | other staff who were ift. She was asked if other  |                   |   |               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                       | (X3) DATE SURVEY<br>COMPLETED   |                        |
|---|--|--|-----------------------|---|------------------------|
|   |  |  | A. BOILDING.          |   |                        |
|   |  | NH2407   | B. WING               |   | C<br><b>07/01/2021</b> |
| NAME OF D   |  | OTDEET AS  | DDEGG GITY GTA        | TE 7/D 00DE   |                        |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STA     |   |                        |
| THE COM   | MONS   | 301 SOU<br>ENID, OK  | TH OAKWOOD F<br>73706 | ROAD  |                        |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE            |
| LL067   | Continued From page  | : 47   | LL067                 |   |                        |
|   | staff members were nathorough investigation "Guess not." She was protected from further they did not initiate and The facility failed to deabuse policy and proof thorough investigation.  7. A grievance conce documented, "Personal death of the Cowould yell at [Residen room to go back, wou door after she went in couldn't open it. She the Med [medication] yanked it around [and When [CMA #4] said a [and] retaliated agains.  Staff Assigned to InvestigateADON] | ot interviewed, was a n completed. She stated, is asked how residents were roccurrence. She stated my new interventions.  evelope and implement an edure for completing a n.  In form, dated 07/24/20, on Filing Complaint[CMA incernWeekend staff int] when she came out of her lid walk her back, close her is [and] hold the door so she eventually came out again, aide grabbed her walker, is anything, she was bullied |                       |   |                        |
|   | to confirm the above on nurse and she stated   | complain. I talked to the no issues were reported to ntl comes out of her room,  |                       |   |                        |
|   | they put a mask on he goResolution[CM/   | er and let her   |                       |   |                        |
|   | didn't back those alleg<br>employee warning for  | gations up. She received an 1) dishonesty,   |                       |   |                        |
|   | manner contrary to re  | conducting one self in a<br>cognized standards of<br>y[On the back of the  |                       |   |                        |
|   | concern form]When [0   | CMA #4] told the nurse, she  |                       |   |                        |
|   | F words. Would throv   | g [and] just said a bunch of<br>v things off the desk [and]<br>hem upThis happened   |                       |   |                        |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     | (X3) DATE SURVEY<br>COMPLETED  |              |     |
|---|---|--|---------------------|--|--------------|-----|
|   |   |  | ,                   |  | С            |     |
|   |   | NH2407   | B. WING             |  | 07/01/2021   |     |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, STA    | TE. ZIP CODE   |              |     |
|   |   |  | TH OAKWOOD F        |  |              |     |
| THE COM   | MONS  | ENID, OK   | 73706               |  |              |     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE COMPLE | ETE |
|   | incident happened on<br>anonymouswants to<br>An employee warning<br>documented, "EMP<br>event07/24/2020F  | as workedThis specific 7/19/20Wants to remain be notified of resolutions"  I notice, dated 07/27/20, LOYEE [CMA#4]Date of PROBLEM/EVENT/INCIDEN misrepresentation about  |                     |  |              |     |
|   | dayACTION TAKEN #1SUSPENSION' CMA #4 was disciplin misrepresentation and  | I:WRITTEN WARNING  ed and written up for d dishonesty as a direct allegation of verbal abuse   |                     |  |              |     |
|   | staff reported suspect they reported it to the their chain of comman months ago, a resider abuse to her and ano DON was busy testing meeting so they went She stated they were chain of command. Streported to if the DON | a.m., LPN #3 was asked who deed abuse to. She stated DON because that was and. She stated, about three and had reported verbal ther nurse. She stated the g staff, the ADM was in a to the admin's assistant. Told they had to go to their the was asked who they was not in the facility. She are reach her on her the cell |                     |  |              |     |
|   | she witnessed abuse month or two ago and She was asked when She stated staff typica of command but the pabuse was her chain to state the incident w   | a.m., CMA # 3 was asked if She stated she did a I she reported it to the ADM. and who did she report to. ally report through the chain berson who had done the of command. She went on vas "traumatizing to me." was afraid to report abuse.   |                     |  |              |     |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| ` '                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|---|-------------------------------|--|
|                          |  |   | 71. BOILBING.                            |   | C                             |  |
|                          |  | NH2407  | B. WING                                  |   | 07/01/2021                    |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA                          | TE, ZIP CODE  |                               |  |
| THE COM                  | MONS   |   | I OAKWOOD F                              | ROAD  |                               |  |
|                          | Г  | ENID, OK  | 73706                                    |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE                   |  |
| LL067                    | Continued From page  | <del>2</del> 49   | LL067                                    |   |                               |  |
|                          | She stated she was was was hold it against her.  | vorried that someone would  |  |   |                               |  |
|                          | On 06/25/21 at 9:50 a.m., LPN #1 was asked if she had ever felt like she could not report incidents of allegations of abuse. She stated, "Yeah." She stated, "Sometimes things don't get done." She stated, "We feel like people should be more in trouble for certain things."  |   |  |   |                               |  |
|                          | At 3:09 p.m., the activity aide was asked if she had ever felt like she could not report allegations of abuse. She stated, "Honestly, yes." She stated, "Last time I reported to her [ADM], she blew me off."  |   |  |   |                               |  |
|                          | #1 and ADM were asl investigation related t  | o.m., the Social Services[SS]<br>ked to describe the<br>o the grievance form dated<br>ed she took the statement |  |   |                               |  |
|                          | The ADM stated the ADON and herself looked at the cameras for the 07/19/20. She was asked if it was for one shift. She stated they looked at the whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No."   |   |  |   |                               |  |
|                          |  | MA #4 received disciplinary ted, "Yes." She was asked   |  |   |                               |  |
|                          | SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against the staff member. She stated CMA #4 wanted to |   |  |   |                               |  |

Oklahoma State Department of Health

STATE FORM 6899 If continuation sheet 50 of 227 C7JI11

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | l ` ′   | CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |             |  |
|---|---|---|-------------------|--|-------------|--|
|   |   |   |                   | <del></del>  | С           |  |
|   |   | NH2407  | B. WING           |  | 07/01/2021  |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, STA | TE, ZIP CODE   |             |  |
| THE COM   | MONS  | 301 SOU<br>ENID, OK                                       | TH OAKWOOD F      | ROAD   |             |  |
| (X4) ID   | SUMMARY STA   | ATEMENT OF DEFICIENCIES                                   | ID                | PROVIDER'S PLAN OF CORRECTION  | V (X5)      |  |
| PREFIX<br>TAG   | (EACH DEFICIENCY  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE |  |
| LL067   | Continued From page   | : 50  | LL067             |  |             |  |
|   | remain anonymous.   |   |                   |  |             |  |
|   | she was fearful of rep<br>She stated, "Yes and<br>was aware, I'd be afra<br>The facility failed to de<br>procedure that ensure<br>reported with retribution<br>On 06/28/21 at 2:42 p<br>acknowledged the face |   |                   |  |             |  |
| LL242   | 1-O.S.63, 1-1918(B)5  | RESIDENT RIGHTS   | LL242             |  |             |  |
| LL242  1-O.S.63, 1-1918(B)5 RESIDENT RIGHTS  Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated; |   |   |                   |  |             |  |

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STATE FORM 6899 C7JI11 If continuation sheet 51 of 227

| Oklahom           | <u>a State Department of</u> | Health   |                   |  |                  |
|-------------------|------------------------------|--|-------------------|--|------------------|
|                   | OF DEFICIENCIES              | (X1) PROVIDER/SUPPLIER/CLIA                        | (X2) MULTIPLE     | CONSTRUCTION   | (X3) DATE SURVEY |
| AND PLAN (        | OF CORRECTION                | IDENTIFICATION NUMBER:                             | A. BUILDING: _    |  | COMPLETED        |
|                   |                              |  |                   |  | С                |
|                   |                              | NH2407   | B. WING           |  | 07/01/2021       |
| NAME OF D         |                              | OTDEST A   |                   | TE 7/D 00DE  |                  |
| NAME OF PI        | ROVIDER OR SUPPLIER          |  | DDRESS, CITY, STA |  |                  |
| THE COM           | MONS                         |  | TH OAKWOOD I      | ROAD   |                  |
|                   |                              | ENID, OF   | 73706             |  |                  |
| (X4) ID<br>PREFIX |                              | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID<br>PREFIX      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD |                  |
| TAG               |                              | SC IDENTIFYING INFORMATION)                        | TAG               | CROSS-REFERENCED TO THE APPROPR                              |                  |
|                   |                              |  |                   | DEFICIENCY)  |                  |
| LL242             | Continued From page          | 51   | LL242             |  |                  |
|                   | Continuou i rom page         | , 61   |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   | This Rule is not met         | as evidenced by:                                   |                   |  |                  |
|                   |                              | ew and staff interviews, it                        |                   |  |                  |
|                   |                              | acility failed to notify the                       |                   |  |                  |
|                   | physician of a change        | in the resident's condition                        |                   |  |                  |
|                   |                              | mpled residents reviewed                           |                   |  |                  |
|                   | for notification.            |  |                   |  |                  |
|                   | <del>-</del>                 |  |                   |  |                  |
|                   |                              | 95 residents resided in the                        |                   |  |                  |
|                   | facility.                    |  |                   |  |                  |
|                   | Findings:                    |  |                   |  |                  |
|                   | i ilidiligs.                 |  |                   |  |                  |
|                   | Resident #7 admitted         | with diagnoses which                               |                   |  |                  |
|                   | included convulsions.        |  |                   |  |                  |
|                   |                              |  |                   |  |                  |
|                   | The resident's care pl       |  |                   |  |                  |
|                   |                              | risk for injury d/t [due to]                       |                   |  |                  |
|                   |                              | Monitor/record time and                            |                   |  |                  |
|                   | duration, type of move       | ement. Report to                                   |                   |  |                  |
|                   | physician"                   |  |                   |  |                  |
|                   | Ni manal mus sus s           | data d 00/00/04                                    |                   |  |                  |
|                   | Nurses' progress note        | es, dated 02/06/21,                                |                   |  |                  |

Oklahoma State Department of Health

documented the resident had a seizure at 4:00

STATE FORM 6899 C7JI11 If continuation sheet 52 of 227 Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED   |               |
|---|---|--|---------------------|---|---------------|
|   |   |  |                     |   | С             |
|   |   | NH2407   | B. WING             |   | 07/01/2021    |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, STA   | TE, ZIP CODE  |               |
| THE COM   | MONS  |  | TH OAKWOOD I        | ROAD  |               |
|   |   | ENID, OK   |                     |   | 1             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE |
| LL242   | Continued From page   | 52   | LL242               |   |               |
|   | a.m. and again at 6:00 documentation the pheither seizure.                                  | 3 a.m. There was no<br>ysician had been notified of  |                     |   |               |
|   |   |  |                     |   |               |
|   | At 3:28 p.m., the assistant director of nursing stated the physician had not been notified. |  |                     |   |               |
|   | was determined the fa<br>physician of a change  | ew and staff interviews, it<br>acility failed to notify the<br>in the resident's condition<br>mpled residents reviewed |                     |   |               |
|   | The facility identified sfacility.  | 95 residents resided in the  |                     |   |               |
|   | Findings:   |  |                     |   |               |
|   | Resident #7 admitted included convulsions.  | with diagnoses which   |                     |   |               |
|   |   | risk for injury d/t [due to]<br>Monitor/record time and  |                     |   |               |
|   |   |  |                     |   |               |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 53 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED  |             |
|---|---|--|---------------------|--|-------------|
|   |   |  |                     |  | С           |
|   |   | NH2407   | B. WING             |  | 07/01/2021  |
| NAME OF PI  | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE   |             |
| THE COMMONS   |   |  | I OAKWOOD F         | ROAD   |             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ENID, OK OATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR | BE COMPLETE |
|   |   |  |                     | DEFICIENCY)  |             |
| LL242   | Continued From page   | ÷ 53   | LL242               |  |             |
|   | asked if the physician activities. She stated according to documen  | ntation.<br>stant director of nursing  |                     |  |             |
| LL244   | 244 1-O.S. 63-1-1918(B)(12) Rights and Responsibilities - Violations  |  | LL244               |  |             |
|   | physical abuse and n defined in Section 10-Oklahoma Statutes, or involuntary seclusion, chemical restraints in discipline or convenie treat the resident's methose restraints author physician for a specifinecessitated by an errestraint may only be qualified licensed nur the supervision of the forth in writing the circuse of restraint. Use restraint shall require | and from any physical and aposed for purposes of since and not required to edical symptoms, except wrized in writing by a led period of time or as are mergency where the applied by a physician, se or other personnel under physician who shall set cumstances requiring the of a chemical or physical |                     |  |             |

Oklahoma State Department of Health

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | , ,   | CONSTRUCTION        | (X3) DATE SURVEY COMPLETED  |             |
|---|---|---|---------------------|---|-------------|
|   |   |   |                     |   | c           |
|   |   | NH2407  | B. WING             |   | 07/01/2021  |
| NAME OF F   | ROVIDER OR SUPPLIER   | STREET A  | ODRESS, CITY, STA   | TE, ZIP CODE  |             |
| THE COM   | MONS  | 301 SOU   | TH OAKWOOD I        | ROAD  |             |
| THE CON   | INIONS  | ENID, OF  | 73706               |   |             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE |
| LL244   | Continued From page   | ÷ 54  | LL244               |   |             |
|   | This REQUIREMENT by: On 06/25/21, an Immosituation was determined facility's failure to ensituation was determined facility's failure to ensituation was allegated for the facility of the facility document being physically abusine physical | ediate Jeopardy (IJ) ned to exist related to the ure residents (#5,6,7,8, and use.  ed that LPN #3 had been eain medications to resident as not reported timely to the acrough investigation was imployee remained working on and no action was taekn  being verbally abusive to 21 was not reported until er the allegation occured. Ot protected as the staff to work.  ed an incident of resident #5 ed by staff witnessed and e facility failed to protect the horough investigation and measures to prevent further  allegation of rape by staff staff had been allowed to |                     |   |             |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 55 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CO  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---------------------|--|-------------------------------|--------------------------|
|   |  |   | 71. 501251110.      |  |                               | С                        |
|   |  | NH2407  | B. WING             |  | 07                            | 7/01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | , ZIP CODE   | -                             |                          |
|   |  | 301 SOL   | ITH OAKWOOD RO      | AD   |                               |                          |
| THE COM   | MONS   | ENID, O   | K 73706             |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETE<br>DATE |
| LL244   | Continued From page  | e 55  | LL244               |  |                               |                          |
|   | an employee and repnot reported to the acthorough investigatio residents were not prepetrator remaining work while the invest.  At 11:04 a.m., the Ok Health (OSDH) was rexistence of the IJ sit.  At 11:28 a.m., the Adnotified of the IJ.  An acceptable, amen provided by the admip.m. It documented to "Plan of AMENDED FTHESE items will be 2021 [By 8:00 p.m.] Misappropriation InveupdatedAn outside in-service on PRN [acadministration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the ADON [assistant direction outside agency. Due 06/28/21 [staff name | g at work and continued to gigtion was on going.  Ilahoma State Department of notified and verified the uation.  Iministrator (ADM) was  ded plan of removal was nistrator on 06/29/21 at 7:20 the following:  Removal for IJ's - ALL completed by June 30th, Abuse, Neglect, estigation POLICY was |                     |  |                               |                          |
|   |  | E team was formed called<br>ONSE TEAM on June 29th,<br>ninistrator, Assistant   |                     |  |                               |                          |

Oklahoma State Department of Health

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | , ,   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|--|-------------------------------|--|
|   |  |   |  |  | С                             |  |
| NH2407  |  | B. WING   |  | 07/01/2021   |                               |  |
| NAME OF PI  | NAME OF PROVIDER OR SUPPLIER STREET AD   |   |  | TE, ZIP CODE   |                               |  |
| THE COMMONS 301 SOUTH   |  |   | I OAKWOOD F<br>73706                     | ROAD   |                               |  |
| (X4) ID   | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID                                       | PROVIDER'S PLAN OF CORRECTION  | N (X5)                        |  |
| PREFIX<br>TAG   | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG                            | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE                   |  |
| LL244   | Continued From page  | e 56  | LL244                                    |  |                               |  |
|   | Administrator, DON, A Center Resident servi administrator or design Director any allegation scheduled monthly man INCIDENT response an outside source on including screening, protection 06/30/21 with advantagement of allegations investigation has been on 07/01/21, two LPN were interviewed and information related to administrative staff were interviewed staff.                   | ADON, and HealthCare ices Director. The gree will report to Board of an of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and as to ensure all thorough |  |  |                               |  |
|   | abuse and neglect.  The immediate ieonal   | rdy deficiency was lifted as  |  |  |                               |  |
|   | The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.  |   |  |  |                               |  |
|   | Based on observation, record review, interviews, it was determined the facility failed to ensure residents were free from abuse and neglect for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse and neglect. The facility also failed to have an environement that ensured staff were free to report allegations of abuse and neglect without fear of retaliation. |   |  |  |                               |  |
|   | The facility identified stacility.   | 95 residents resided in the   |  |  |                               |  |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 57 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE Co    | (X2) MULTIPLE CONSTRUCTION                             |                                   |                          |
|---|--|---------------------|--|-----------------------------------|--------------------------|
| AND PLAN OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING:        |  | COMI                              | PLETED                   |
|   |  |                     |  |                                   | С                        |
|   | NH2407   | B. WING             |  | 07                                | 7/01/2021                |
| NAME OF PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATE | . ZIP CODE   |                                   |                          |
|   |  | TH OAKWOOD RO       |  |                                   |                          |
| THE COMMONS   | ENID, OF   |                     | AD   |                                   |                          |
| (VA) ID SUMMARY ST  | TATEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF                                     | CORRECTION                        | (VE)                     |
| PREFIX (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244 Continued From page   | e 57   | LL244               |  |                                   |                          |
| Findings:   |  |                     |  |                                   |                          |
| preventabuse byl adverse action when report any genuine or regardingabuseT retaliation, in any form making a report, comfaithAbuse & Negle ABUSE OR NEGLEC MUST BE REPORTE IMMEDIATELYFAIL OR NEGLECT, EVEN NEGLECT, LEAVES THE SITUATIONBu Commons will not, in or harassing behavior violation of this policy including termination and/or harassment: Verbalridiculinghu voice at in individual Cell PhonesCell photime onlyCode of ComproceduresViolation rulesmay result in cup to and including depression abuse of the resident or mental abuse by the MediaEmployees in confidentialabout not disparage any performed immediately | Company actively works to Protecting employeesfrom they do the right thing and concern he Company strictly prohibits m, against any individual uplaint, or inquiry in good act PolicyNO FORM OF CT IS TOLERATED AND ED LURE TO REPORT ABUSE N SUSPECTED ABUSE OR YOU RESPONSIBLE FOR callying & HarassmentThe ay instance, tolerate bullying r. Employees found in will be disciplined, up to andexamples of bullying umiliatingShouting, raising in publicTelephone Calls & tone use is limited to break conductDisciplinary ns of any of these corrective action being taken, ischargePhysical or mental is or failure to report physical othersSocial |                     |  |                                   |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 58 of 227

| Oklahom:      | <u>a State Department of</u> | Health  |                  |   |             |                  |
|---------------|------------------------------|---|------------------|---|-------------|------------------|
|               | OF DEFICIENCIES              | (X1) PROVIDER/SUPPLIER/CLIA                         | (X2) MULTIPLE    | CONSTRUCTION  | (X3) DATE S |                  |
| AND PLAN C    | OF CORRECTION                | IDENTIFICATION NUMBER:                              | A. BUILDING: _   |   | COMPLE      | ≣TED             |
|               |                              |   |                  |   |             | :                |
|               |                              | NH2407  | B. WING          |   | 1           | ,<br>1/2021      |
| NAME OF B     |                              | 070557.10   |                  | TE 7/0 000E   |             |                  |
| NAME OF PI    | ROVIDER OR SUPPLIER          |   | DRESS, CITY, STA |   |             |                  |
| THE COMMONS   |                              | 'H OAKWOOD F  | ROAD             |   |             |                  |
|               |                              | ENID, OK  | 73706            |   |             |                  |
| (X4) ID       |                              | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL | ID               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD |             | (X5)<br>COMPLETE |
| PREFIX<br>TAG | ,                            | LSC IDENTIFYING INFORMATION)                        | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APPROPR                                 |             | DATE             |
|               |                              |   |                  | DEFICIENCY)   |             |                  |
| LL244         | Continued From page          | . 50  | LL244            |   |             |                  |
| LLZ44         | Continued From page          | 3 30  |                  |   |             |                  |
|               |                              | rsThese allegations must                            |                  |   |             |                  |
|               |                              | gated and must prevent                              |                  |   |             |                  |
|               | •                            | e while the investigation is in                     |                  |   |             | ,                |
|               |                              | e action must be taken                              |                  |   |             |                  |
|               |                              | e appropriate licensing                             |                  |   |             |                  |
|               |                              | t [sic] the policy of The                           |                  |   |             |                  |
|               |                              | resident will be free from                          |                  |   |             | ,                |
|               |                              | acility staff will be in-serviced                   |                  |   |             | ,                |
|               |                              | nt, and at least annually                           |                  |   |             | ,                |
|               | thereafter, regarding.       |   |                  |   |             |                  |
|               | 1                            | report any suspicion of                             |                  |   |             | ,                |
|               | _                            | streatment to your immediate                        |                  |   |             | ,                |
|               |                              | ervisor WILL CALL the CELL                          |                  |   |             | ,                |
|               | l -                          | STRATOR [admin], then the substantiated cases must  |                  |   |             |                  |
|               |                              | espective agencies such as                          |                  |   |             | ,                |
|               | -                            | nforcement, physician;                              |                  |   |             |                  |
|               |                              | ent responsible party. The                          |                  |   |             |                  |
|               | 1                            | ll be routinely and openly                          |                  |   |             |                  |
|               |                              | tionProcedure1stCare                                |                  |   |             |                  |
|               | _                            | CT the resident-DON,                                |                  |   |             |                  |
|               |                              | ervisor should do a medical                         |                  |   |             |                  |
|               | I                            | itelydocumenting any injury                         |                  |   |             |                  |
|               | in detailTake a state        |   |                  |   |             |                  |
|               |                              | e the perpetrator3rd                                |                  |   |             |                  |
|               |                              | the Administrator, then DON                         |                  |   |             | ,                |
|               | "                            |   |                  |   |             | ,                |
|               |                              |   |                  |   |             | ı                |
|               |                              | liagnoses which included                            |                  |   |             |                  |
|               | chronic pain and oste        | oarthritis.   |                  |   |             |                  |
|               |                              |   |                  |   |             | ı                |
|               | A resident assessmer         |   |                  |   |             |                  |
|               | documented the resid         | •   |                  |   |             |                  |
|               | moderately impaired.         |   |                  |   |             |                  |
|               |                              |   |                  |   |             |                  |
|               |                              | date 01/07/21, documented,                          |                  |   |             |                  |
|               |                              | for pain r/t [related to]                           |                  |   |             |                  |
|               | muscle spasms and o          |   |                  |   |             |                  |
| ļ             | syndromeResident             | will nave pain                                      |                  |   |             | i                |

Oklahoma State Department of Health

treated/relieved in a timely manner...Administer

STATE FORM 6899 C7JI11 If continuation sheet 59 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE C   |                     | (X3) DATE SURVEY<br>COMPLETED  |                |
|---|---|---|---------------------|--|----------------|
|   |   |   | 720.250.            | <del></del>  | С              |
|   |   | NH2407  | B. WING             |  | 07/01/2021     |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, STATE | E. ZIP CODE  |                |
|   |   |   | TH OAKWOOD RO       |  |                |
| THE COM   | MONS  | ENID, OK  |                     |  |                |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE |
| LL244   | Continued From page   | ÷ 59  | LL244               |  |                |
|   | medications as presci   | ribed"  |                     |  |                |
|   | "hydrocodone 7.5 mg<br>325 mg tablet (Norco)<br>every 8 hours as need   | ated 06/08/21, documented, [milligrams]-acetaminophen of give 1 tablet by oral routed ded FOR CHRONIC PAIN ule give 2 tablets by oral is needed for pain  |                     |  |                |
| Ultram 50 mg tablet give 1 tablet (50 mg) by or route every 6 hours as needed for pain"             |   | ` ,   |                     |  |                |
|   | 12:35 a.m., document multiple occasions, ty in the morning after the [Resident #9] get up of ask for a pain pill. He Norco and rate his part butt pain. As protocorequest to the charge go to the resident to expert back to me, the administer a pain med level of the pain that velocation of the [sic] pain [LPN #3], will deny the name], pain meds standoesn't need a pain persone a cigarette, he he can go outside to spain pill because he he on these occurances | but of bed for the day, he will a will specifically ask for a in at an 8 out of 10 for leg or I, as the CMA, I report the nurse, the charge nurse will evaluate the resident and a CMA, with guidance to d and instruct me with the was reported and the n. On many occurances, a resident, [Resident's ting 'He just got up, he ill' or 'He's going outside to 's not hurting bad enough if smoke' or 'He can't have a nasn't eaten anything yet.'  [Resident] won't receive times 10 a.m or as late a 2 ne MAR [medication] |                     |  |                |
|   | An OSDH incident for documented, "[Resi   | m, dated 06/26/21,<br>dent #9]Allegations of  |                     |  |                |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |                 |
|---|--|---|--|--|-----------------|
|   |  | 756.256.  |  |  |                 |
| NH2407  |  | B. WING   |  | C<br>07/01/2021  |                 |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, STATE                      | E, ZIP CODE  |                 |
| TUE 001   | MANA   | 301 SOU   | TH OAKWOOD RO                            | DAD  |                 |
| THE COM   | MONS   | ENID, OK  | 73706                                    |  |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE COMPLETE |
| LL244   | Continued From page  | ÷ 60  | LL244                                    |  |                 |
|   | Abuse/Mistreatment<br>IncidentStaff report<br>pain meds when resid<br>Resident is cognitive<br>called"   | ed Nurse not approving PRN<br>lent asked for them.  |  |  |                 |
|   | 12:23 [did not docum<br>documented, "Somet<br>pills when it is not tim<br>is scheduled [every] {   | I #3, dated 06/27/21 at ent a.m. or p.m.], mes resident asks for pain e as he had it earlier. Med I [hours] prn. Resident is co can't be given yet"   |  |  |                 |
|   |  | nducted with five residents.<br>to the residents were not<br>ain medications.   |  |  |                 |
|   |  | ed the allegation was<br>completed on 06/27/21 at   |  |  |                 |
|   | The employee continuinvestigation of the all   | ued to work during the eged negelct.  |  |  |                 |
|   | The facility did not co investigation and inte include the alleged vi medications being with   | rview residents and staff to ctim regarding pain  |  |  |                 |
|   | assistant administrator conclusion of the investad administrator stated as spreadsheet of which versus the Norco. She had administered the other nurses. She was documentation of the requested the Norco. | p.m., the administrator and or were asked about the estigation. The assistant the had made an excel nurse had given Tylenol are stated the accused nurse medications as much as the as asked if there was times the resident had She stated she didn't think as had requested it. She was |  |  |                 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |                              |                          |
|---|---|---|--|--|------------------------------|--------------------------|
|   |   |   |  |  | С                            |                          |
|   |   | NH2407  | B. WING                                  |  | 07                           | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, STATE                       | E, ZIP CODE  |                              |                          |
| THE COM   | MONS  |   | TH OAKWOOD RO                            | DAD  |                              |                          |
|   |   | ENID, OK  | 73706                                    |  |                              |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244   | Continued From page   | 61  | LL244                                    |  |                              |                          |
|   | resident requested it withheld the medication conclusion the allegares and she went   | documentation of when the and the CMA stated LPN #3 on, how did they come to the tion was unsubstantiated. to the resident and asked ted the resident is this leader.   |  |  |                              |                          |
|   | There were no questi<br>related to staff withho<br>stated the executive of<br>surveys and thought to<br>members respect you   | If provided resident surveys.  ons asked to the residents Iding pain medications. She director had made the that the question "Do staff or requests and allow you to ding your care" covered  |  |  |                              |                          |
|   | if he was in pain. He right side, leg and know rate it at an 8 out of 1 a 9 in the mornings. He did not get his Nor He stated, "If I don't gwas asked if his Norce stated it was and ther | o.m., the resident was asked stated he had pain in his ee. She stated he would 0. He stated it was usually He was asked how he felt if to when he requested it. Let them, I get mad." He o was ever withheld. He in stated he would not bloyee was that witheld the   |  |  |                              |                          |
|   | allegations made regard Norco. She stated, "I the time." She stated when he asks for som have to follow." She give the same responstatement. She state their pain as they state           | was asked about the arding LPN #3 withholding Norco is what he asks for all I, "It's upsetting to me cause nething, I have protocol I stated that LPN #3 would uses CMA #3 had put in her d she was taught to take led it. She stated LPN #3 hister Tylenol or Ultram |  |  |                              |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   |                                   |                          |  |
|---|--|---|---|---|-----------------------------------|--------------------------|--|
|   |  | NUMBER  | B. WING                                 |   |                                   | C<br>07/01/2021          |  |
|   |  | NH2407  |   |   | 07                                | 7/01/2021                |  |
| NAME OF P   | PROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE                     |   |                                   |                          |  |
| THE COM   | IMONS  | 301 SOU<br>ENID, OI   | ITH OAKWOOD RO                          | AD  |                                   |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| LL244   | Continued From page  | e 62  | LL244                                   |   |                                   |                          |  |
|   |  | dmitted to the facility with uded convulsions and   |   |   |                                   |                          |  |
|   |  | assessment, dated 02/18/21,<br>dent's cognition was severely  |   |   |                                   |                          |  |
|   | documented, "Incide Abuse/Mistreatment IncidentAdministrat allegation of verbal affrom a staff member is not on the schedule not be working until the investigated. Investigated and final reports, of the investigation implemented to prevent attached for investigaters. She was su | tor was notified today of an buse occurring on 02/22/21 against a nurse. The nurse e until Thursday. She will he allegation has been gation is in progressFor 5 please include a summary and corrective measures ent recurrenceSee ation: Nurse yelled at uspended and counseled on urnout. Also gave her |   |   |                                   |                          |  |
|   | admininistraor until the   | se was not reported to the next day after it occured.   |   |   |                                   |                          |  |
|   |  | ne appropriate agencies such<br>te Department of Health   |   |   |                                   |                          |  |
|   | documented, "The da<br>spent a majority of th<br>hallway outside of [ar<br>approximately 2 p.m.  | by CMA #3, dated 02/23/21, ay of 2-22-21, [resident #7] e day sitting in the North Hall nother resident]s room. At [resident #7] wheeled hair up closer to the nurse's  |   |   |                                   |                          |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   |   | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED   |             |
|--|---|---|---------------------|---|-------------|
|  |   |   | 7. BOILBING.        |   | c           |
|  |   | NH2407  | B. WING             |   | 07/01/2021  |
| NAME OF PROVIDER O   | R SUPPLIER  | STREET AD   | DRESS, CITY, STA    | JE. ZIP CODE  | -           |
|  |   |   | TH OAKWOOD I        |   |             |
| THE COMMONS  |   | ENID, OK  | 73706               |   |             |
|  | ACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE |
| LL244 Continu  | ed From page  | e 63  | LL244               |   |             |
| station a outside Immedia and yell here, you here." [ yelled a at her, he to health again "getalk to me [residen nurse's his room sitting in entire extended and he seemed a said I do and he seemed and he seemed a witter the docume getting at [residen feesiden fees | area and park of the wound ately the charged to [residen u're not going Resident #7] t [LPN #3]. It is speech is on conditions. Let the hell oune that way." t #7] wheeled station area benDuring this is a chair besid vent"  In statement beneficially a station [LPN # and go back it on the care Im not station [LPN # and go back it ont care Im not said he wantered at him and its on the station [LPN # and go back it ont care Im not said he wantered at him and its ont sitting unit on your Ass. So it [LPN #3] let vening"  In statement beneficially and the wantered its one that the other wantered its one that wantered its | ed himself in his wheelchair care nurse's office.  ge nurse, [LPN #3], stood up t #7] "get the hell out of g to sit up here while I'm did raise his hands and do not know what he yelled often hard to make out due [LPN #3] then yelled at him to fhere, you're not going to After this occurrence, himself away from the tack down the hall towards occurrence, [CMA #4] was the me and witnessed the set gonna [CMA #4] was the Common Area by the set gonna [Sic] deal with you do to sit up here She said "I dont give a dam [Sic] p here Im not gonna [Sic] the nurse told him to turn the said he has rights She said "I dont give a dam [Sic] p here Im not gonna [Sic] p here Im not gonna [Sic] p here Im not gonna [Sic] the was very upset the rest of the |                     |   |             |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | , ,   | (X2) MULTIPLE CONSTRUCTION |  |                                   |                          |  |
|---|---|---|----------------------------|--|-----------------------------------|--------------------------|--|
| ANDILAN   | OI CONNECTION   | IDENTIFICATION NOWIBER.   | A. BUILDING:               | A. BUILDING:   |                                   | COMPLETED                |  |
|   |   |   | B WING                     | B WING   |                                   | С                        |  |
|   |   | NH2407  | B. WING                    |  | 07                                | 7/01/2021                |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE        | , ZIP CODE   |                                   |                          |  |
| THE COM   | MONO  | 301 SOU   | TH OAKWOOD RO              | AD   |                                   |                          |  |
| THE COM   | IMONS   | ENID, OF  | C 73706                    |  |                                   |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| LL244   | Continued From page   | e 64  | LL244                      |  |                                   |                          |  |
|   | 5:00 p.m., documente [administrator (admin back [and] was told the against me for yelling Monday February 22 [approximately] [2:00 the man but suppose [admin] via the camer told I told male reside hall or go to his room to sit in the area by wit congests the hallwat towards the resident.  | p.m.]Not only did I yell [at] dly I cussed [at] him also per ras. No AudioWas also ent to go away, go down the . I had asked residents not round care Nurse's office as ayMay of raised my voice" |                            |  |                                   |                          |  |
|   | A investigative summary, undated, documented, "Who is/are the reported victim[resident #7]Who is/are the reported perpetrator[LPN #3]Who witnessed the incident[CMA #3], [CNA #3], [CNA #4]What happenedResidentwas in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the deskWhat is the history of the resident(s)? Was the incident foreseeableThe resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeableWhat does the victim want to happen[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulderWhen did the incident happenAround 2pm on Feb [February] 22ndWhen was facility supervisory/management staff first contacted about the incidentOn Feb 23rd" |   |                            |  |                                   |                          |  |
|   |   | of Nursing complaint form,<br>/21, documented, "Nurse's   |                            |  |                                   |                          |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED  |                 |
|---|--|---|---------------------|--|-----------------|
|   |  |   | A. BUILDING         |  |                 |
|   |  | NH2407  | B. WING             |  | C<br>07/01/2021 |
| NAME OF D   |  |   |                     | FF 71D 00DF  | 1 01/01/2021    |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STAT  |  |                 |
| THE COM   | MONS   |   | TH OAKWOOD R        | COAD   |                 |
|   |  | ENID, OK  |                     |  |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE COMPLETE |
| LL244   | Continued From page  | e 65  | LL244               |  |                 |
|   | or Criminal Behavior. abuseDescription or suspended pending the returned to work on 0 disciplinary action writed a resident and for concontrary to recognized employment at the fact A time sheet for pay properties. A time sheet for pay properties on 02/27/21, documented p.m. on 02/22/21. LP4 hours and 48 minuted The facility failed to properties of the facility failed to reside the suspension of the facility failed to reside the facility failed to reside the suspension of the facility failed to reside the suspension of the facility failed to reside the facility failed to reside the facility failed to reside the suspension of the facility failed to reside the facility | f InvestigationLPN was ne investigation and 2/26/2021. She received te up for raising her voice at aducting herself in a manner d standards. Her cility is being retained"  Deriod from 02/14/21 to d LPN #3 worked til 6:48 N #3 worked approximately es after the abuse occurred. |                     |  |                 |
|   | to describe the incide 02/22/21 with resident resident is hard of her didn't yell. She stated took statements from and discussed the incidence of the was asked 02/22/21. She stated asked when the incidence stated she was notified was asked what the cowas. She stated it was did it. She stated she write up. She was astolerance for abuse, hand book is wrong."   |   |                     |  |                 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  |                      | (X3) DATE SURVEY<br>COMPLETED  |      |                          |
|---|--|---|----------------------|--|------|--------------------------|
| ANDILAN   | or dorate of the transfer of t | IDENTIFICATION NOWIDEN.   | A. BUILDING:         |  |      |                          |
|   |  | NH2407  | B. WING              |  | 07/0 | ;<br>1/2021              |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA      | TE, ZIP CODE   |      |                          |
| THE COM   | MONS   | 301 SOUTH<br>ENID, OK 1   | I OAKWOOD I<br>73706 | ROAD   |      |                          |
| 040.1=  | CLIMMADY CT.   | · · · · · · · · · · · · · · · · · · ·   |                      | DROVIDER'S DI AN OF CORRECTION   | NI.  | 0.450                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE   | (X5)<br>COMPLETE<br>DATE |
| LL244   | Continued From page  | e 66  | LL244                |  |      |                          |
|   | anything else other th<br>was asked who the st<br>abuse to. She stated<br>asked when the staff<br>did they report timely.<br>asked if the staff who<br>inserviced about repo<br>"Nothing in writing."  | ne stated they didn't add<br>an what was in place. She<br>aff can report suspected<br>, "Any authority." She was<br>had witnessed the abuse,<br>She stated, "No." She was<br>witnessed the abuse were<br>riting timely. She stated, |                      |  |      |                          |
|   | On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."   |   |                      |  |      |                          |
|   | The ADM was asked after the incident. Sh   | if the resident was assessed<br>e stated, "No."   |                      |  |      |                          |
|   | not immediately repor  | no witnessed the abuse did<br>t it. As a result, LPN #3<br>n and other residents for<br>ours and 48 minutes.  |                      |  |      |                          |
|   | place to prevent abus<br>result, one of the with<br>allegation of verbally.<br>The facility substantia<br>terminated CMA #4 w<br>employeed by the fac  | hile LPN #3 continued to be iltiy.  |                      |  |      |                          |
|   | diagnoses which inclu  | dmitted to the facility with uded dementia.   |                      |  |      |                          |

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|   | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:           | ` '                | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--------------------|--|-------------------------------|--|
| AND FLAN                                | OF CORRECTION   | IDENTIFICATION NUMBER.                                       | A. BUILDING:       |  | COMPLETED                     |  |
|   |   |  |                    |  | С                             |  |
|   |   | NH2407   | B. WING            |  | 07/01/2021                    |  |
| NAME OF P                               | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STAT | E, ZIP CODE  |                               |  |
|   |   | 301 SOU  | TH OAKWOOD R       | OAD  |                               |  |
| THE COM                                 | MONS  | ENID, OI   | K 73706            |  |                               |  |
| (X4) ID                                 | SUMMARY ST  | ATEMENT OF DEFICIENCIES                                      | ID                 | PROVIDER'S PLAN OF CORRECT   | TION (X5)                     |  |
| PREFIX<br>TAG                           |   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG      | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETE               |  |
| LL244                                   | Continued From page   | e 67   | LL244              |  |                               |  |
|   | A quarterly resident a  | ssessment, dated 05/02/21,                                   |                    |  |                               |  |
|   |   | dent's cognitive skills for                                  |                    |  |                               |  |
|   |   | was severely impaired.                                       |                    |  |                               |  |
|   |   | ,  |                    |  |                               |  |
|   | An initial incident repo  | ort form, dated 06/07/21,                                    |                    |  |                               |  |
|   | -   | dentInvolved[resident  |                    |  |                               |  |
|   | #5]Incident TypeA   | _  |                    |  |                               |  |
|   | Abuse/Mistreatment  | •  |                    |  |                               |  |
|   | IncidentReceived an allegation of abuse towards a resident by staff member. Staff |  |                    |  |                               |  |
|   |   |  |                    |  |                               |  |
| member suspended pending investigation" |   |  |                    |  |                               |  |
|   | A written statement from CMA #2, dated  |  |                    |  |                               |  |
|   |   | d "Around [8:30 a.m.] [CNA                                   |                    |  |                               |  |
|   |   | Id come help her I told her                                  |                    |  |                               |  |
|   |   | cond because I was in the                                    |                    |  |                               |  |
|   |   | of another Resident. When                                    |                    |  |                               |  |
|   | _   | t #5]'s room [CNA #2] had                                    |                    |  |                               |  |
|   |   | nt arm yanking [and] pulling                                 |                    |  |                               |  |
|   |   | s slapping at his left leg,-on                               |                    |  |                               |  |
|   |   | t her to stop doing him that                                 |                    |  |                               |  |
|   |   | e what [and] just kind of                                    |                    |  |                               |  |
|   | 1   | the bed, she went to pull on I told her to just leave that I |                    |  |                               |  |
|   |   | m. I brought him out for                                     |                    |  |                               |  |
|   |   | ne Charge Nursewhat had                                      |                    |  |                               |  |
|   |   | n [LPN #2] talked to [CNA                                    |                    |  |                               |  |
|   | 1 *   | ay away from direct care of                                  |                    |  |                               |  |
|   |   | I seen [sic] D.O.Naround                                     |                    |  |                               |  |
|   | [10:00 a.m.] I asked it   | f [LPN #2] had talk to her                                   |                    |  |                               |  |
|   |   | at had happened She told                                     |                    |  |                               |  |
|   |   | e but now she is [and]                                       |                    |  |                               |  |
|   | asked me to write out   | t a statement"   |                    |  |                               |  |
|   | A written statement fr  | rom LPN #2, dated 06/07/21,                                  |                    |  |                               |  |
|   |   | #2] came to me and stated "I                                 |                    |  |                               |  |
|   |   | cause she came out to ask                                    |                    |  |                               |  |
|   |   | esident #5] up I went into the                               |                    |  |                               |  |
|   |   | and he was mad and hitting                                   |                    |  |                               |  |
|   |   | her grab his arm and swat                                    |                    |  |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  |                     | (X3) DATE SURVEY<br>COMPLETED   |      |                          |
|---|---|---|---------------------|---|------|--------------------------|
| 74101 2741  | or connection   | IDENTIFICATION NOMBER   | A. BUILDING:        |   |      |                          |
|   |   | NH2407  | B. WING             |   | 07/0 | )<br>1/2021              |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |      |                          |
| THE COM   | MONS  |   | I OAKWOOD F         | ROAD  |      |                          |
|   | OUR MADY OF   | ENID, OK  |                     |   |      |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE   | (X5)<br>COMPLETE<br>DATE |
| LL244   | Continued From page   | e 68  | LL244               |   |      |                          |
|   | finish him, I went to [0 happened she said I  | her to leave and I would<br>CNA #2] and asked what<br>was just playing and I would<br>as told by nurse to stay out of |                     |   |      |                          |
|   | documented, "[residesided [sic] to get his then uncovered him swas getting him dress his pull-up on the [sic] after that I took his hoready to put his arm is went to put his head in the shirt down. tried to si on leg to Push Leg in have my other hand a him sit up. then holle stand him to finish ge was fighting me. I was [sic] him down to resus [CMA #2] came in the hold him up. then toke the [sic] she would ge abusing him. I Left the room, then the nurse her no i was patting him. | ne room and went the Break<br>eask me if i hit him I told<br>iim to try come [sic] him<br>me not go around him again. |                     |   |      |                          |
|   | "Who isthe reported #5]who isreported #2]What happened yanking on Residents legWhat was done from further harmSt  | -   |                     |   |      |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |                 |  |
|---|---|--|--|---|-----------------|--|
|   |   |  | 7. BOILBING                              |   | С               |  |
|   |   | NH2407   | B. WING                                  |   | 07/01/2021      |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STAT                       | TE. ZIP CODE  | •               |  |
|   |   |  | TH OAKWOOD R                             | ·   |                 |  |
| THE COM   | MONS  | ENID, OF   | C 73706                                  |   |                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE COMPLETE |  |
| LL244   | Continued From page   | e 69<br>then was suspended and   | LL244                                    |   |                 |  |
|   | sent home pending in DONWhat is the his the incident foreseeal of being combative to deliveredWhen did happen06/07/21, [7 supervisory/managen about the incident[1 A final state report, da"A skin sweep was by two nurses with no Accused perpetrator of 06/07/2021 pending a 06/08/2021 she was of the Administrator. Shor what could be consulso completed a Reli Understanding Deme | expestigation by the story of the residentWas obleResident has a history of staff when cares are the incident sign a.m.]When was facility ment staff first contacted 0:00 a.m.]"  Sated 06/08/21, documented, completed on the resident of injuries notedThe was suspended on an investigation. On counseled by the DON and the received verbal education sidered to be abuse. She its Training entitled |  |   |                 |  |
|   | documented she worl a.m. to 10:04 a.m., ar a.m. and on 06/08/21 and from 1:57 p.m. to The facility had docur unsubstantited even t and failed to complete interviewing other sta On 06/24/21 at 12:48 to describe her invest she would complete a   | dated 06/06/21 to 06/19/21, ked on 06/07/21 from 6:30 and from 10:36 a.m. to 11:37 from 8:27 a.m. to 1:27 p.m., 2:32 p.m.  mented the allegation was through there was a witness, e a thourgh investigation by ff members and residents.  p.m., the DON was asked igation process. She stated an incident report, remove ke statements from other  |  |   |                 |  |
|   | staff on the hall that th   | ne incident occurred and son cognitive residents on  |  |   |                 |  |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED  |                       |
|---|--|--|--|---|--------------------------------|-----------------------|
|   |  | NH2407   | B. WING                                  |   | 07                             | C<br><b>7/01/2021</b> |
| NAME OF D   |  | 1  | DDDESS SITV STATE                        | 7/0 0005  | 1 0.                           | 70172021              |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STATE                      |   |                                |                       |
| THE COM   | MONS   |  | ITH OAKWOOD RC<br>K 73706                | IAU   |                                |                       |
| (V4) ID   | SUMMARY ST   | TATEMENT OF DEFICIENCIES   | ID                                       | PROVIDER'S PLAN OF (  | CORRECTION                     | (X5)                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG                            | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | COMPLETE<br>DATE      |
| LL244   | Continued From page  | e 70   | LL244                                    |   |                                |                       |
|   | was asked if staff wo stated not always. S considered interview on other halls. She so other staff but not oth asked when the investated on 06/07/21 a when the investigation stated late on 06/07/2 thorough investigation stated, "I feel it was to  | ing other staff and residents stated she has interviewed her residents. She was stigation was started. She to 10:00 a.m. She was asked on was completed. She 21. She was asked if a n was conducted. She horough." She was asked if essed after incident for   |  |   |                                |                       |
|   | 06/07/21. She stated lunch and when she suspended and sent she worked on 06/08 here at 8:30 a.m. to relias training then rwas asked what discreceived. She stated about dementia, she and two and a half howas asked what complace to prevent furth residents. She stated The DON stated she happened because 0 and she called the C | home. She was asked when 1/21. She stated she was meet with DON and watch eturned to the floor. She iplinary actions CNA #2 If she watched Relias video was suspended on the 7th ours on the 8th. The DON ective actions were put in her abuse and protect the d there were no changes. didn't feel the allegation CNA #2 left the door open MA for help. She lid not notify DON or ADM of |  |   |                                |                       |
|   | immediately and as a work with other resid   | t incident to the DON a result, CNA #2 continued to ents for approximately one a half hours. A thorough  |  |   |                                |                       |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE C  |                     |   | E SURVEY<br>PLETED             |                          |
|---|--|--|---------------------|---|--------------------------------|--------------------------|
|   |  | NH2407   | B. WING             |   | 07                             | C<br>7/ <b>01/2021</b>   |
| NAME OF F   | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STATE | , ZIP CODE  |                                |                          |
| THE COM   | IMONS  | 301 SOU<br>ENID, OF  | TH OAKWOOD RO       | AD  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244   | interviewing other st it is unknown if othe involved.  4. Resident #8 had pressure ulcer to the vacuum (vac) and p.  A time record for RN documented she wo a.m.  A time record for CN documented she wo a.m.  A progress note, dat documented, "She she was raped by 50 minutesStaff is not themselves. This was per policy"  On 06/28/21 at 5:20 observed to be at th When approached, a call that a resident They were asked wh call. One stated, "A At 5:25 a.m., the aditalk to you guys." S lady who says she withe two ladies home.  An OSDH incident redocumented, "Fina of Abuse/Mistreatment | diagnoses which included e sacrum requiring a wound ain.  I #2, dated 06/27/21, brked from 5:33 p.m. to 5:39  IA #5, dated 06/27/21, brked from 10:01 p.m. to 5:39  Ited 06/28/21 at 4:23 a.m., e than [sic] began saying that 0 females every 30 to go in her room by as reported to administration  a.m., two police officers were e front door to the facility. they stated they had received to had been sexually abused. Then they had received they ha | LL244               |   |                                |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CO  |                     |   | (X3) DATE SURVEY<br>COMPLETED    |                          |
|---|--|---|---------------------|---|----------------------------------|--------------------------|
|   |  |   | 7.1. 20.23.110.     |   |                                  | С                        |
|   |  | NH2407  | B. WING             |   | 07                               | 7/01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | , ZIP CODE  |                                  |                          |
| THE COM   | IMONG  | 301 SOU   | TH OAKWOOD RO       | AD  |                                  |                          |
| THE COM   | IMON5  | ENID, OF  | K 73706             |   |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244   | was also saying we was also saying we was also saying we was when staff CMA gave [signs/symptoms] of pay and final reports, of the investigation | were trying to poison her her ultramNo S/S obysical rape notedFor 5 please include a summary See attached  Inter and time of report at 5:10 p.m., documented, orted perpetrator(s)A mWhat on of Rape and bed to protect the resident(s) taff was to always go in that was done upon discovery the daministratorWhat is physical done at 5PM facility the ent staff first contacted 1:47 PM [06/27/21]"  #2 documented, p.m. to 11:15 p.m.] Resident there was bed bugs in her bed. If by 2 staff and found no an [sic] began saying that the seen yelling these that the rapest [sic] is a sign of them every 5 minutes. Soribe themStaff has been the 2 people and then after tration we have been going | LL244               | DEFICIENC   | Y)                               |                          |
|   | 12:32 p.m., documer<br>#8] started yellingS<br>yelling rape. She sai<br>everyone has been ra   | A #5, dated 06/28/21 ay nted, "At 11:14 pm [Resident hortly after she started d she was raped and that aped. She said that she has minutes by 50 people"  |                     |   |                                  |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 73 of 227

Oklahoma State Department of Health

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                  | CONSTRUCTION   | (X3) DATE SUI |                  |
|--------------------------|--|---|----------------------|--|---------------|------------------|
| ANDILAN                  | or connection  | IDENTIFICATION NOMBER.  | A. BUILDING: _       | A. BUILDING:   |               |                  |
|                          |  | NH2407  | B. WING              |  | 07/01         | /2021            |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, STA     | TE, ZIP CODE   |               |                  |
| THE COM                  | MONS   | 301 SOUT<br>ENID, OK  | H OAKWOOD I<br>73706 | ROAD   |               |                  |
| (V4) ID                  | SUMMARY ST   | ATEMENT OF DEFICIENCIES   | ID                   | PROVIDER'S PLAN OF CORREC  | CTION         | (X5)             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | PREFIX<br>TAG        | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE        | COMPLETE<br>DATE |
| LL244                    | Continued From page  | e 73  | LL244                |  |               |                  |
|                          |  | 6/28/21, from CNA #7,<br>ent stated she was being<br>peatedly"  |                      |  |               |                  |
|                          | documented, "On 6<br>[resident #8's room n   | 6/28/21, from CMA #5<br>i-28-2021, resident in RM<br>umber] has been yelling<br>and saying the police are                             |                      |  |               |                  |
|                          | On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us." |   |                      |  |               |                  |
|                          | with the resident last<br>She stated she had in<br>the family and physic<br>resident. She stated<br>assessed. The admin<br>nurse, "You can't rape<br>close to." She was a  | the resident refused to be nistrator stated she told the e someone you can't get sked who the two staff were g with the resident. She |                      |  |               |                  |
|                          | The ADM was asked  | how she proteceted the  |                      |  |               |                  |

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| NAME OF PROVIDER OR SUPPLIER  THE COMMONS  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD ENID, OK 73706  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                    |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|--|--|--------------------|--|-------------------------------|--------------------------|
| THE COMMONS 301 SOUTH OAKWOOD ROAD   |   |  | NH2407   | B. WING            |  |                               | _                        |
| THE COMMONS  | NAME OF F   | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, STAT | E, ZIP CODE  |                               |                          |
| FNID OK 73706  | THE COM   | IMONS  | 301 SOU  | TH OAKWOOD R       | OAD  |                               |                          |
| LNID, OK 13100   | THE CON   | INIONS   | ENID, OK   | 73706              |  |                               |                          |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM  | PREFIX  | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL   | PREFIX             | (EACH CORRECTIVE ACTION SECTION SECTIO | HOULD BE                      | (X5)<br>COMPLETE<br>DATE |
| LL244  Continued From page 74  residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."  On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.  Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted herthat the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated  On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents (#5,6,7,8, and #9) were free from abuse.  A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation on action was teach | LL244   | residents once she wallegation of rape. So with two, always two facility policy was for was an allegation of a find the policy." She reading it. She stated them, suspend." She two staff had been suat the time." She sta She was asked what She stated, "I don't kis She was asked if her employees for allega followed. She stated On 06/29/21 at 11:30 regarding resident #8 reviewed with the AD her report on the staff. Reviewed with the AD her report on the staff. | ras made aware of the he stated, "I told her to go in "She was asked what the protecting residents if there abuse. She stated, "Let me located the policy and began d, "Immediately remove e was asked if either of the ispended. She stated, "Not ted, "I came and did it later." time she suspended them. how, I was with the police." policy for suspending tions of abuse had been, "No."  a.m., the investigation allegation of rape was ident described the slike us" and that the ocumented the resident was cription. The ADM stated  Mediate Jeopardy (IJ) and to exist related to the sure residents (#5,6,7,8, and ouse.  Bed that LPN #3 had been pain medications to resident as not reported timely to the norough investigation was employee remained working | LL244              |  |                               |                          |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |                                |                          |
|--|--|---|--|--|--------------------------------|--------------------------|
|  |  | NH2407  | B. WING                                  |  | 0.5                            | C<br>7/ <b>01/2021</b>   |
|  |  | NF12407   |  |  | 01                             | 7/01/2021                |
| NAME OF P  | ROVIDER OR SUPPLIER  |   | ADDRESS, CITY, STAT                      |  |                                |                          |
| THE COM  | MONS   |   | JTH OAKWOOD R<br>K 73706                 | OAD  |                                |                          |
| 040.15   | STIMMADY ST  | ATEMENT OF DEFICIENCIES   |  | PROVIDER'S PLAN OF O                                       | CORRECTION                     | 0/5)                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244  | Continued From page  | e 75  | LL244                                    |  |                                |                          |
|  | against the nurse.   |   |  |  |                                |                          |
|  | resident #7 on 02/22/<br>02/23/21, one day aft   | being verbally abusive to /21 was not reported until ter the allegation occured. ot protected as the staff to work. |  |  |                                |                          |
|  | The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.  Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made. |   |  |  |                                |                          |
|  |  |   |  |  |                                |                          |
|  | an employee and rep<br>not reported to the ac<br>thorough investigatio<br>residents were not pr  | g at work and continued to  |  |  |                                |                          |
|  |  | lahoma State Department of notified and verified the uation.  |  |  |                                |                          |
|  | At 11:28 a.m., the Ad notified of the IJ.  | ministrator (ADM) was   |  |  |                                |                          |
|  |  | ided plan of removal was<br>nistrator on 06/29/21 at 7:20<br>the following:   |  |  |                                |                          |
|  | "Plan of AMENDED F   | Removal for IJ's - ALL  |  |  |                                |                          |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE A. BUILDING: _ | (X3) DATE SURVEY<br>COMPLETED  |               |
|--------------------------|---|---|------------------------------|--|---------------|
|                          |   |   | A. BOILBING.                 |  | C             |
|                          |   | NH2407  | B. WING                      | <del></del>  | 07/01/2021    |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AD   | DDRESS, CITY, STAT           | TE, ZIP CODE   | -             |
| THE COM                  | MONG  | 301 SOUT  | TH OAKWOOD F                 | ROAD   |               |
| THE COM                  | MONS  | ENID, OK  | 73706                        |  |               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETE |
| LL244                    | Continued From page   | <del>2</del> 76   | LL244                        |  |               |
|                          | 2021 [By 8:00 p.m.] Misappropriation InveupdatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the ADON [assistant directoutside agency. Due 06/28/21 [staff name of [CNA #6] and [LPN #506/30/21  | astigation POLICY was agency will provide a needed] pain medication A, and Nursing on June will focus on neglect, and not ons. All staff that have not une 30th, 8pm may not work the DON [director of nursing], ctor of nursing], or the to further consideration on deleted] was terminated.  By will be terminated on  |                              |  |               |
|                          | the INCIDENT RESPONDANCE And includes the Administrator, DON, A Center Resident serving administrator or design Director any allegation scheduled monthly mand INCIDENT responses an outside source on including screening, protection 06/30/21 with advarsalways protect our response team will mare respond to allegations investigation has been on 07/01/21, two LPN were interviewed and | ONSE TEAM on June 29th, inistrator, Assistant ADON, and HealthCare ices Director. The gnee will report to Board of an of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and is to ensure all thorough |                              |  |               |
|                          | administrative staff we   | abuse and neglect and five ere interviewed and were information related to  |                              |  |               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | CONSTRUCTION     | (X3) DATE SURVEY COMPLETED   |                 |
|---|--|---|------------------|--|-----------------|
|   |  |   | A. BUILDING:     |  |                 |
|   |  | NH2407  | B. WING          |  | C<br>07/01/2021 |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STA | TE ZIP CODE  | -               |
| NAME OF T   | NOVIDEN ON GOLL FIELD  |   | TH OAKWOOD F     |  |                 |
| THE COM   | MONS   | ENID, OK  |                  | COAD   |                 |
| (X4) ID   | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID               | PROVIDER'S PLAN OF CORRECTIO   | N (X5)          |
| PREFIX<br>TAG   | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE     |
| LL244   | Continued From page  | : 77  | LL244            |  |                 |
|   | of 06/30/21 at 5:10 p. plan of removal and the had been implemente remained at a level of Based on observation it was determined the residents were free from six (#1, 5, 6, 7, 8 and residents reviewed for facility also failed to hensured staff were free abuse and negelct with       | rdy deficiency was lifted as m. when all elements of the ne amended plan of removal d. The deficient practice factual harm at a pattern.  In, record review, interviews, facility failed to ensure om abuse and neglect for #9) of six sampled rabuse and neglect. The ave an environement that the to report allegations of thout fear of retaliation.                                     |                  |  |                 |
|   | Findings:  |   |                  |  |                 |
|   | preventabuse byF adverse action when report any genuine co regardingabuseTh retaliation, in any form making a report, comp faithAbuse & Negleo ABUSE OR NEGLEC MUST BE REPORTE IMMEDIATELYFAIL OR NEGLECT, EVEN NEGLECT, LEAVES THE SITUATIONBu Commons will not, in or harassing behavior | Company actively works to Protecting employeesfrom they do the right thing and oncern the Company strictly prohibits in, against any individual plaint, or inquiry in good at PolicyNO FORM OF T IS TOLERATED AND DURE TO REPORT ABUSE IS SUSPECTED ABUSE OR YOU RESPONSIBLE FOR Illying & HarassmentThe ay instance, tolerate bullying a Employees found in will be disciplined, up to and |                  |  |                 |

Oklahoma State Department of Health

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|                          | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | ` '                 | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--------------------------------|--|---------------------|--|-------------------------------|
|                          |                                |  | A. BUILDING: _      |  |                               |
|                          |                                |  |                     |  | С                             |
|                          |                                | NH2407   | B. WING             |  | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER            | STREET AI  | DDRESS, CITY, STA   | TE, ZIP CODE   |                               |
|                          |                                |  | TH OAKWOOD F        |  |                               |
| THE COM                  | MONS                           | ENID, OF   |                     |  |                               |
| (V4) ID                  | SLIMMARY ST.                   | ATEMENT OF DEFICIENCIES                                    |                     | PROVIDER'S PLAN OF CORRE   | CTION (VE)                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPL<br>DEFICIENCY) | OULD BE COMPLETE              |
| LL244                    | Continued From page            | e 78   | LL244               |  |                               |
|                          | and/or harassment:             |  |                     |  |                               |
|                          |                                | ımiliatingShouting, raising                                |                     |  |                               |
|                          | _                              | in publicTelephone Calls &                                 |                     |  |                               |
|                          |                                | one use is limited to break                                |                     |  |                               |
|                          | time onlyCode of C             | onductDisciplinary   |                     |  |                               |
|                          | ProceduresViolation            | ns of any of these   |                     |  |                               |
|                          | rulesmay result in c           | corrective action being taken,                             |                     |  |                               |
|                          | up to and including di         | schargePhysical or mental                                  |                     |  |                               |
|                          |                                | s or failure to report physical                            |                     |  |                               |
|                          | or mental abuse by o           |  |                     |  |                               |
|                          | MediaEmployees m               | •  |                     |  |                               |
|                          |                                | clientsEmployees should                                    |                     |  |                               |
|                          | not disparage any pe           | rsonbased ondisability"                                    |                     |  |                               |
|                          | An abuse policy date           | ed 12/08/2020, documented,                                 |                     |  |                               |
|                          |                                | entsallegations shall be                                   |                     |  |                               |
|                          |                                | to the administrator, DON                                  |                     |  |                               |
|                          |                                | n accordance with State                                    |                     |  |                               |
|                          |                                | involve abusemust be                                       |                     |  |                               |
|                          | _                              | rsThese allegations must                                   |                     |  |                               |
|                          | · ·                            | gated and must prevent                                     |                     |  |                               |
|                          | further potential abus         | e while the investigation is in                            |                     |  |                               |
|                          | progressappropriate            | e action must be taken                                     |                     |  |                               |
|                          |                                | e appropriate licensing                                    |                     |  |                               |
|                          |                                | t [sic] the policy of The                                  |                     |  |                               |
|                          |                                | resident will be free from                                 |                     |  |                               |
|                          | _                              | acility staff will be in-serviced                          |                     |  |                               |
|                          |                                | nt, and at least annually                                  |                     |  |                               |
|                          | thereafter, regarding.         | •  |                     |  |                               |
|                          | -                              | report any suspicion of                                    |                     |  |                               |
|                          |                                | streatment to your immediate                               |                     |  |                               |
|                          |                                | ervisor WILL CALL the CELL STRATOR [admin], then the       |                     |  |                               |
|                          |                                | substantiated cases must                                   |                     |  |                               |
|                          |                                | espective agencies such as                                 |                     |  |                               |
|                          | -                              | nforcement, physician;                                     |                     |  |                               |
|                          |                                | ent responsible party. The                                 |                     |  |                               |
|                          |                                | I be routinely and openly                                  |                     |  |                               |
|                          |                                | tionProcedure1stCare                                       |                     |  |                               |
|                          |                                | CT the resident-DON,                                       |                     |  |                               |

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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |                         |
|---|--|---|----------------------------|---|-------------------------------|-------------------------|
| ,   |  | .52.11.1.0, 11.0.11.0   | A. BUILDING:               |   |                               |                         |
|   |  | NH2407  | B. WING                    |   | O7/01/20                      | )21                     |
| NAME OF PR  | OVIDER OR SUPPLIER   | STREET ADD  | DRESS, CITY, STA           | TE, ZIP CODE  |                               |                         |
| THE COMM  | MONS   | 301 SOUTI<br>ENID, OK   | H OAKWOOD F<br>73706       | ROAD  |                               |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE CO                       | (X5)<br>OMPLETE<br>DATE |
|   | assessment immediatin detailTake a state resident2ndIsolateImmediately notify ti"  1. Resident #9 had dichronic pain and oste A resident assessment documented the reside moderately impaired.  A care plan, effective "Resident is at risk to muscle spasms and disyndromeResident treated/relieved in a timedications as presconditude to the provide the provided in the medications as prescondituded in the provided in the medications as need to the provided in the provided in the mortal state of the provided in the mortal state of the provided in the mortal state of the provided in the provided in the mortal state of the provided in the provided in the mortal state of the provided in the provided in the mortal state of the provided in the mortal state of the provided in the provided in the mortal state of the provided in the mortal state of the provided in the provided | ervisor should do a medical telydocumenting any injury ement from the ethe perpetrator3rd he Administrator, then DON iagnoses which included oarthritis.  Int, dated 01/14/21, then it's cognition was date 01/07/21, documented, for pain r/t [related to] thronic pain will have pain mely mannerAdminister ribed"  Inted 06/08/21, documented, [milligrams]-acetaminophen of give 1 tablet by oral route ded FOR CHRONIC PAIN  Intel give 2 tablets by oral is needed for pain  Intel tablet (50 mg) by oral is needed for pain  Intel tablet (50 mg) by oral is needed for pain  Intel tablet (50 mg) by oral is needed for pain  Intel tablet (50 mg) by oral is needed for pain | LL244                      |   |                               |                         |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 80 of 227

Oklahoma State Department of Health

| Oklanoma State Department of Fleatin |                               |   |                  | Taras = .== =                               |                       |          |
|--------------------------------------|-------------------------------|---|------------------|---|-----------------------|----------|
|                                      | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                  | CONSTRUCTION                                | (X3) DATE S<br>COMPLE |          |
| MIND I LAIN (                        | J. JOHNEOHOW                  | IDENTIFICATION NOWIDER.                               | A. BUILDING: _   |   | CONFL                 |          |
|                                      |                               |   |                  |   |                       | :        |
| NH2407                               |                               | B. WING   |                  | 1   | 1/2021                |          |
|                                      |                               |   | <u> </u>         |   | 1 0170                |          |
| NAME OF PI                           | ROVIDER OR SUPPLIER           | STREET AD   | DRESS, CITY, STA | TE, ZIP CODE                                |                       |          |
| THE COM                              | MONS                          | 301 SOUT  | H OAKWOOD I      | ROAD  |                       |          |
| THE COM                              | WIONS                         | ENID, OK  | 73706            |   |                       |          |
| (X4) ID                              | SUMMARY STA                   | ATEMENT OF DEFICIENCIES                               | ID               | PROVIDER'S PLAN OF CORRECTION               | ١                     | (X5)     |
| PREFIX                               | ,                             | Y MUST BE PRECEDED BY FULL                            | PREFIX           | (EACH CORRECTIVE ACTION SHOULD              |                       | COMPLETE |
| TAG                                  | REGULATORY OR L               | SC IDENTIFYING INFORMATION)                           | TAG              | CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | RIATE                 | DATE     |
|                                      |                               |   |                  | 52.10.2.1017                                |                       |          |
| LL244                                | Continued From page           | <del>2</del> 80                                       | LL244            |   |                       |          |
|                                      | request to the charge         | nurse, the charge nurse will                          |                  |   |                       |          |
|                                      |                               | evaluate the resident and                             |                  |   |                       |          |
|                                      | report back to me, the        | e CMA, with guidance to                               |                  |   |                       |          |
|                                      |                               | d and instruct me with the                            |                  |   |                       |          |
|                                      | level of the pain that v      | was reported and the                                  |                  |   |                       |          |
|                                      | location of th [sic] pair     | n. On many occurances,                                |                  |   |                       |          |
|                                      | [LPN #3], will deny the       | e resident, [Resident's                               |                  |   |                       |          |
|                                      | name], pain meds sta          | ting 'He just got up, he                              |                  |   |                       |          |
|                                      |                               | ill' or 'He's going outside to                        |                  |   |                       |          |
|                                      | •                             | 's not hurting bad enough if                          |                  |   |                       |          |
|                                      | <u> </u>                      | smoke' or 'He can't have a                            |                  |   |                       |          |
|                                      |                               | nasn't eaten anything yet.'                           |                  |   |                       |          |
|                                      |                               | , [Resident] won't receive                            |                  |   |                       |          |
|                                      | •                             | times 10 a.m or as late a 2                           |                  |   |                       |          |
|                                      | p.m. as reflected on the      |   |                  |   |                       |          |
|                                      | administration record]        | <b>"</b>  |                  |   |                       |          |
|                                      | An OSDH incident for          | m, dated 06/26/21,                                    |                  |   |                       |          |
|                                      |                               | dent #9]Allegations of                                |                  |   |                       |          |
|                                      | Abuse/Mistreatment            |   |                  |   |                       |          |
|                                      | IncidentStaff reporte         | ed Nurse not approving PRN                            |                  |   |                       |          |
|                                      | pain meds when resid          |   |                  |   |                       |          |
|                                      | Resident is cognitive         | and needs no family                                   |                  |   |                       |          |
|                                      | called"                       |   |                  |   |                       |          |
|                                      | Δ statement from LDN          | √ #3, dated 06/27/21 at                               |                  |   |                       |          |
|                                      | 12:23 [did not docume         | •   |                  |   |                       |          |
|                                      | =                             | mes resident asks for pain                            |                  |   |                       |          |
|                                      |                               | e as he had it earlier. Med                           |                  |   |                       |          |
|                                      |                               | B [hours] prn. Resident is                            |                  |   |                       |          |
|                                      |                               | co can't be given yet"                                |                  |   |                       |          |
|                                      | 55.54 Tylonor II 14010        |   |                  |   |                       |          |
|                                      | Safe survevs were co          | inducted with five residents.                         |                  |   |                       |          |
|                                      |                               | to the residents were not                             |                  |   |                       |          |
|                                      | related to receiving pa       |   |                  |   |                       |          |
|                                      |                               |   |                  |   |                       |          |
|                                      | The facility document         | ed the allegation was                                 |                  |   |                       |          |
|                                      | _                             | completed on 06/27/21 at                              |                  |   |                       |          |
|                                      | 5:30 p.m.                     | •   |                  |   |                       |          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|--|---|-------------------------------|--------------------------|
|   |   |   |  |   |                               | С                        |
|   |   | NH2407  | B. WING                                  |   | 07                            | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE                      | , ZIP CODE  |                               |                          |
| THE COM   | MONS  | 301 SOU   | TH OAKWOOD RO                            | AD  |                               |                          |
| THE COM   | WONS  | ENID, OF  | K 73706                                  |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETE<br>DATE |
| LL244   | Continued From page   | e 81  | LL244                                    |   |                               |                          |
|   | The employee continuinvestigation of the all  |   |  |   |                               |                          |
|   |   | rview residents and staff to ctim regarding pain  |  |   |                               |                          |
|   | assistant administrate conclusion of the investad administrator stated is spreadsheet of which versus the Norco. She had administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it withheld the medicatic conclusion the allegations. | times the resident had She stated she didn't think had requested it. She was documentation of when the had the CMA stated LPN #3 hon, how did they come to the home tion was unsubstantiated. https://documentation.org/li> |  |   |                               |                          |
|   | There were no questi<br>related to staff withho<br>stated the executive of<br>surveys and thought<br>members respect you  | If provided resident surveys.  ons asked to the residents olding pain medications. She director had made the that the question "Do staff or requests and allow you to be ding your care" covered                            |  |   |                               |                          |
|   | if he was in pain. He right side, leg and known   | o.m., the resident was asked<br>stated he had pain in his<br>ee. She stated he would<br>0. He stated it was usually   |  |   |                               |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                      |   | (X3) DATE SURVEY<br>COMPLETED  |                          |
|--|---|---|----------------------|---|--------------------------------|--------------------------|
|  |   |   | A. BOILDING.         |   |                                |                          |
|  |   | NH2407  | B. WING              |   | 0.7                            | C<br>7/ <b>01/2021</b>   |
|  |   | · · · · · · · · · · · · · · · · · · ·   | I                    |   | 1 07                           | 70 172021                |
| NAME OF P  | ROVIDER OR SUPPLIER   |   | ADDRESS, CITY, STATE |   |                                |                          |
| THE COM  | MONS  |   | JTH OAKWOOD RO       | AD  |                                |                          |
|  |   | ENID, O   | K 73706              |   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244  | Continued From page   | e 82  | LL244                |   |                                |                          |
|  | he did not get his Not<br>He stated, "If I don't g<br>was asked if his Nord<br>stated it was and the  | He was asked how he felt if roo when he requested it. get them, I get mad." He so was ever withheld. He in stated he would not bloyee was that witheld the  |                      |   |                                |                          |
|  | allegations made reg<br>Norco. She stated, "I<br>the time." She stated<br>when he asks for son<br>have to follow." She<br>give the same respor<br>statement. She state<br>their pain as they star                           | B was asked about the arding LPN #3 withholding Norco is what he asks for all d, "It's upsetting to me cause nething, I have protocol I stated that LPN #3 would nses CMA #3 had put in hered she was taught to take ted it. She stated LPN #3 nister Tylenol or Ultram |                      |   |                                |                          |
|  |   | dmitted to the facility with uded convulsions and   |                      |   |                                |                          |
|  |   | essessment, dated 02/18/21,<br>dent's cognition was severely  |                      |   |                                |                          |
|  | documented, "Incid<br>Abuse/Mistreatment<br>IncidentAdministrat<br>allegation of verbal al<br>from a staff member<br>is not on the schedule<br>not be working until the<br>investigated. Investig<br>day and final reports, | or was notified today of an buse occurring on 02/22/21 against a nurse. The nurse a until Thursday. She will the allegation has been gation is in progressFor 5 please include a summary and corrective measures  |                      |   |                                |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED    |                          |
|---|---|---|--|--|----------------------------------|--------------------------|
|   |   | A. BOILDING.  |  |  | С                                |                          |
|   |   | NH2407  | B. WING                                  |  | 07                               | '/ <b>01/2021</b>        |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, STATE                      | , ZIP CODE   | •                                |                          |
| <b>TUE 001</b>  |   |   | TH OAKWOOD RO                            |  |                                  |                          |
| THE COM   | MONS  | ENID, OK  | 73706                                    |  |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TON SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244   | Continued From page   | e 83  | LL244                                    |  |                                  |                          |
|   | attached for investiga<br>resident. She was su<br>ways to recognize bu<br>Employee Assistance   | rnout. Also gave her  |  |  |                                  |                          |
|   |   | se was not reported to the e next day after it occured.   |  |  |                                  |                          |
|   | within two hours to th  | eport the allegation of abuse<br>e appropriate agencies such<br>te Department of Health   |  |  |                                  |                          |
|   | documented, "The da spent a majority of the hallway outside of [ar approximately 2 p.m. himself in his wheelch station area and park outside of the wound Immediately the chargand yelled to [residen here, you're not going here." [Resident #7] yelled at [LPN #3]. It is to health conditions, again "get the hell out talk to me that way." [resident #7] wheeled nurse's station area to his roomDuring this | y CMA #3, dated 02/23/21, by of 2-22-21, [resident #7] be day sitting in the North Hall nother resident]s room. At [resident #7] wheeled nair up closer to the nurse's ed himself in his wheelchair care nurse's office. ge nurse, [LPN #3], stood up at #7] "get the hell out of a to sit up here while I'm did raise his hands and do not know what he yelled often hard to make out due [LPN #3] then yelled at him at of here, you're not going to After this occurrence, I himself away from the back down the hall towards occurrence, [CMA #4] was de me and witnessed the |  |  |                                  |                          |
|   | documented, "On Mo<br>#4] came into work I  | y CMA #4, dated 02/24/21,<br>nday February 22nd I [CMA<br>was on North Hall. I was<br>on [resident #7] the resident   |  |  |                                  |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     | (X3) DATE SURVEY<br>COMPLETED  |               |
|---|--|--|---------------------|--|---------------|
|   |  |  | С                   |  |               |
|   |  | NH2407   | B. WING             |  | 07/01/2021    |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AL  | DDRESS, CITY, STA   | TE, ZIP CODE   |               |
| THE COM   | MONS   | 301 SOU  | TH OAKWOOD F        | ROAD   |               |
| THE COM   | MONO   | ENID, OK   | 73706               |  |               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY) | D BE COMPLETE |
| LL244   | nurses station [LPN # around and go back h said I dont care Im no and he said he wante screamed at him and your [sic] not sitting u deal with your Ass. sc Corner til [LPN #3] let of the evening"  A written statement by documented, "The ott getting something what [resident #7]. And [Resident #7] started #3] got louder and tol listen to it. Go to you Im sick of him acting I A written statement by 5:00 p.m., documente [administrator (admin back [and] was told the against me for yelling Monday February 22r [approximately] [2:00 the man but suppose [admin] via the camer told I told male reside hall or go to his room | ne Common Area by the 13] the nurse told him to turn he said he has rights She of gonna [sic] deal with you do to sit up here She said "I dont give a dam [sic] pour here Im not gonna [sic] p | LL244               | DEFICIENCY)  |               |
|   | it congests the hallwad towards the resident  A investigative summularWho is/are the reputationWho is/are the resident   | yMay of raised my voice ." ary, undated, documented, orted victim[resident eported perpetrator[LPN the incident[CMA #3],   |                     |  |               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                        | (X3) DATE SURVEY<br>COMPLETED  |             |
|---|--|---|------------------------|--|-------------|
|   |  |   | B. WING                |  | С           |
|   |  | NH2407  | B. WING                |  | 07/01/2021  |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STA      |  |             |
| THE COM   | MONS   | 301 SOU <sup>-</sup><br>ENID, OK  | ΓH OAKWOOD F<br>∷73706 | ROAD   |             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR | BE COMPLETE |
| LL244   | sitting near the nurse came down the hall a leave the deskWhat resident(s)? Was the resident has had outbreason a staff member should this incident was not for victim want to happen discuss the incident, I would like to happen, shoulderWhen did to 2pm on Feb [February supervisory/managen about the incidentO  An Oklahoma Board of submitted date 02/26/Name: [LPN #3]Did or Criminal Behavior abuseDescription of suspended pending the returned to work on Odisciplinary action write a resident and for concontrary to recognized employment at the fact A time sheet for pay proceed to the power of the facility failed to proper abuse during the investment of the staff of the pattern of the facility failed to proper abuse during the investment of the staff of the pattern of the facility failed to proper abuse during the investment of the pattern | was in his wheelchair is desk. [LPN #3] the nurse and started yelling at him to at is the history of the incident foreseeableThe preaks lately, but there is NO ar should yell at a resident. It does the history of the incident foreseeableWhat does the himiliar is should not be the himiliar is shou | LL244                  | DEFICIENCY)  |             |
|   |  | port the allegation timely to<br>a through investigation was  |                        |  |             |

Oklahoma State Department of Health

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Oklahoma State Department of Health

| Oklanom       | a State Department of  | neaith   |                            |   |                  |  |
|---------------|------------------------|--|----------------------------|---|------------------|--|
|               | OF DEFICIENCIES        | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY |  |
| AND PLAN (    | OF CORRECTION          | IDENTIFICATION NUMBER:                                     | A. BUILDING:               |   | COMPLETED        |  |
|               |                        |  |                            |   | С                |  |
|               | NU 10 407              |  | B. WING                    |   |                  |  |
|               |                        | NH2407   | 2: :::::0                  |   | 07/01/2021       |  |
| NAME OF P     | ROVIDER OR SUPPLIER    | STREET AL  | DRESS, CITY, STA           | TE, ZIP CODE  |                  |  |
|               |                        | 301 SOU  | TH OAKWOOD I               | ROAD  |                  |  |
| THE COM       | MONS                   | ENID, OK   |                            | TOAD  |                  |  |
|               |                        | ENID, OR   | 13706                      |   |                  |  |
| (X4) ID       |                        | ATEMENT OF DEFICIENCIES                                    | ID                         | PROVIDER'S PLAN OF CORRECTION                                 | ( -/             |  |
| PREFIX<br>TAG |                        | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG              | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP |                  |  |
| iAO           |                        | ,  | 17.0                       | DEFICIENCY)   |                  |  |
|               |                        |  | +                          |   |                  |  |
| LL244         | Continued From page    | e 86   | LL244                      |   |                  |  |
|               |                        |  |                            |   |                  |  |
|               | On 06/22/21 at 2:24 m  | o mo the admin was saled                                   |                            |   |                  |  |
|               |                        | o.m., the admin was asked                                  |                            |   |                  |  |
|               | to describe the incide | • •  |                            |   |                  |  |
|               | 02/22/21 with residen  |  |                            |   |                  |  |
|               |                        | aring and LPN #3 stated she                                |                            |   |                  |  |
|               | •                      | d she reviewed the cameras,                                |                            |   |                  |  |
|               |                        | the witnesses and LPN #3                                   |                            |   |                  |  |
|               |                        | cident with the resident's                                 |                            |   |                  |  |
|               |                        | when LPN #3 worked on                                      |                            |   |                  |  |
|               |                        | I she didn't know. She was                                 |                            |   |                  |  |
|               |                        | ent was reported. She                                      |                            |   |                  |  |
|               | stated she was notifie | ed on the following day. She                               |                            |   |                  |  |
|               | was asked what the c   | outcome of her investigation                               |                            |   |                  |  |
|               | was. She stated it wa  | as substantiated that LPN #3                               |                            |   |                  |  |
|               | did it. She stated she | e was suspended and had a                                  |                            |   |                  |  |
|               | write up. She was as   | sked if the facility had a zero                            |                            |   |                  |  |
|               | tolerance for abuse.   | She stated, "If I say yes, my                              |                            |   |                  |  |
|               | hand book is wrong."   | She was asked what was                                     |                            |   |                  |  |
|               | done to protect and p  | revent this from happening                                 |                            |   |                  |  |
|               |                        | he stated they didn't add                                  |                            |   |                  |  |
|               |                        | nan what was in place. She                                 |                            |   |                  |  |
|               |                        | taff can report suspected                                  |                            |   |                  |  |
|               |                        | l, "Any authority." She was                                |                            |   |                  |  |
|               |                        | had witnessed the abuse,                                   |                            |   |                  |  |
|               |                        | . She stated. "No." She was                                |                            |   |                  |  |
|               | , ,                    | witnessed the abuse were                                   |                            |   |                  |  |
|               |                        | orting timely. She stated,                                 |                            |   |                  |  |
|               | "Nothing in writing."  | orang amory. One states,                                   |                            |   |                  |  |
|               | . Tourning in writing. |  |                            |   |                  |  |
|               | On 06/24/21 at 1:00 r  | o.m., the DON was asked if                                 |                            |   |                  |  |
|               |                        | ed on 02/22/21 around 2:00                                 |                            |   |                  |  |
|               |                        | s." She was asked if LPN #3                                |                            |   |                  |  |
|               | •                      |  |                            |   |                  |  |
|               |                        | er. She stated, "Yes." She                                 |                            |   |                  |  |
|               |                        | continued to work with                                     |                            |   |                  |  |
|               |                        | the resident protected. She                                |                            |   |                  |  |
|               |                        | t be, because we didn't know                               |                            |   |                  |  |
|               |                        | sked, since the staff failed to                            |                            |   |                  |  |
|               |                        | ediately, were the residents                               |                            |   |                  |  |
|               | protected. She stated  | d, "No."   |                            |   |                  |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                     |
|---|--|---|--|---|-------------------------------|---------------------|
|   |  | NH2407  | B. WING                                  |   | I                             | C<br><b>01/2021</b> |
|   |  |   | -  |   | 1 077                         | 01/2021             |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STATE                      |   |                               |                     |
| THE COM   | MONS   | 301 SOU<br>ENID, OK   | TH OAKWOOD RO                            | JAD   |                               |                     |
| (X4) ID   | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID                                       | PROVIDER'S PLAN OF CORREC   | TION                          | (X5)                |
| PREFIX<br>TAG   | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG                            | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE                        | COMPLETE<br>DATE    |
| LL244   | Continued From page  | e 87  | LL244                                    |   |                               |                     |
|   | The ADM was asked after the incident. Sh   | if the resident was assessed e stated, "No."  |  |   |                               |                     |
|   | not immediately repor  | ho witnessed the abuse did<br>rt it. As a result, LPN #3<br>n and other residents for<br>ours and 48 minutes.   |  |   |                               |                     |
|   | place to prevent abus<br>result, one of the with<br>allegation of verbally<br>The facility substantia  | hile LPN #3 continued to be   |  |   |                               |                     |
|   | Resident #5 was addiagnoses which inclu  | dmitted to the facility with uded dementia.   |  |   |                               |                     |
|   | documented the resid   | ssessment, dated 05/02/21,<br>lent's cognitive skills for<br>was severely impaired.   |  |   |                               |                     |
|   | documented, "Resid<br>#5]Incident TypeA<br>Abuse/Mistreatment<br>IncidentReceived at<br>towards a resident by  | Description of allegation of abuse  |  |   |                               |                     |
|   | #2] asked me if I coul<br>yes just give me a sec<br>middle of taking care<br>I walked into [residen<br>ahold [sic] of his Righ<br>on him while she was | om CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had t arm yanking [and] pulling slapping at his left leg,-on |  |   |                               |                     |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                  | (X3) DATE SURVEY<br>COMPLETED  |                        |
|---|--|---|------------------|--|------------------------|
|   |  |   | 7. BOLEBING.     |  |                        |
|   |  | NH2407  | B. WING          |  | C<br><b>07/01/2021</b> |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STA | TE ZIP CODE  |                        |
| NAME OF T   | NOVIDEN ON GOLT EIEN   |   | H OAKWOOD F      |  |                        |
| THE COM   | MONS   | ENID, OK  |                  | NOAD .   |                        |
| (X4) ID   | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID               | PROVIDER'S PLAN OF CORRECTION  | N (X5)                 |
| PREFIX<br>TAG   | ,  | Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE            |
| LL244   | Continued From page  | e 88  | LL244            |  |                        |
|   | dropped him back on his arm to get him up would take care of hir breakfast [and] told the just happened. Where #2] she told her to state [resident #5]. When It [10:00 a.m.] I asked if [and] I told [DON] what me she was not aware asked me to write out.  A written statement for documented, "[CMA #2] become to help get him [recome where she was at her states she saw at his left leg so I told finish him, I went to [Chappened she said I would to the same to help get him [recome where she was at her states she saw at his left leg so I told finish him, I went to [Chappened she said I would to the same to help get him [recome where she was at her states she saw at his left leg so I told finish him, I went to [Chappened she said I would happened | e what [and] just kind of the bed, she went to pull on I told her to just leave that I m. I brought him out for the Charge Nursewhat had the Charge Nursewhat had the LPN #2] talked to [CNA the saway from direct care of the seen [sic] D.O.Naround for [LPN #2] had talk to her the that happened She told the but now she is [and] the a statement"  The cause she came out to ask the sident #5] up I went into the the the sand he was mad and hitting ther grab his arm and swat ther to leave and I would the could be playing and I would the stold by nurse to stay out of the same to be stay out of the second she was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the stold by nurse to stay out of the same that I was just playing and I would the same that I was just playing and I would the same that I was just playing and I would the same that I was just playing and I would the same that I was just playing and I would the same that I was just playing the same that I was just |                  |  |                        |
|   | documented, "[resic desided [sic] to get his then uncovered him s was getting him dress his pull-up on the [sic] after that I took his ho ready to put his arm is went to put his head h   | om CNA #2, dated 06/07/21,<br>dent #5] was awake. So<br>m up. got his clothes ready<br>started talking to him while<br>sed. I started by putting [sic]<br>I then i put his pants on.<br>ospital gown off. got his shirt<br>n. then put the arm in as I<br>his shirt, I told him not to Bite   |                  |  |                        |
|   | shirt down. tried to si<br>on leg to Push Leg in<br>have my other hand a<br>him sit up. then holle   | te whole [sic] [and] pull his t him up By Putting my arm a sitting position while i around upper back to help red [sic] at [CMA #2] to help tting dressed. Because he   |                  |  |                        |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:  C  NH2407  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  THE COMMONS  301 SOUTH OAKWOOD ROAD  ENID, OK 73706   | TEAN OF CORREC   |  |
|--|--|--|
| NH2407  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  THE COMMONS  301 SOUTH OAKWOOD ROAD   |  |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  THE COMMONS  301 SOUTH OAKWOOD ROAD   |  |  |
| THE COMMONS 301 SOUTH OAKWOOD ROAD   |  |  |
| THE COMMONS  | IE OF PROVIDER OI  |  |
| ENID. OK 73706   | COMMONS  |  |
|  |  |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | REFIX (E   |  |
| LL244 Continued From page 89 LL244   | L244 Continu   |  |
| was fighting me. I was patting hisleg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurseask me if I hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise"  An investigative summary, undated, documented, "Who isthe reported venture[resident #5]Who isreported prepertator[CNA #2]What happenedAllegation that CNA was yanking on Residents arm and slapping his legWhat was done to protect the resident(s) from further harmStaff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DONWhat is the history of the residentWas the incident foreseeableResident has a history of being combative to staff when cares are deliveredWhen did the incident happen06/07/21, [7-30 a.m.]When was facility supervisory/management staff first contacted about the incident[10:00 a.m.]When was facility supervisory/management staff first contacted about the incident[10:00 a.m.]When was facility supervisory/management staff first contacted about the incident incident[10:00 a.m.]When was facility supervisory/management staff first contacted about the incident incident[10:00 a.m.]When was facility supervisory/management staff first contacted about the incident incident[10:00 a.m.]When was facility supervisory/management staff first contacted about the incident incident[10:00 a.m.]When was facility supervisory/management staff first contacted about the incident incident[10:00 a.m.]When was completed on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be ab | was figh [sic] him [CMA #2 hold him the [sic] abusing room. the first her no in down. [sic] with the first her no in down. If the first her no in down in white first her no in the first her no in |  |

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|                          | FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE C     |  | , , ,                             | E SURVEY<br>PLETED       |
|--------------------------|---|---|---------------------|--|-----------------------------------|--------------------------|
|                          |   |   | A. BUILDING:        |  |                                   | _                        |
|                          | NH2407  |   | B. WING             |  | 0.7                               | C<br>// <b>01/2021</b>   |
|                          |   |   |                     |  | 1 07                              | 70 17202 1               |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE |  |                                   |                          |
| THE COM                  | MONS  | 301 SOU<br>ENID, OF   | TH OAKWOOD RC       | IAD  |                                   |                          |
| (VA) ID                  | SLIMMADV ST   | ATEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF                                     | COPPECTION                        | (V5)                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL244                    | Continued From page   | e 90  | LL244               |  |                                   |                          |
|                          | 06/08/2021"   |   |                     |  |                                   |                          |
|                          | documented she wor<br>a.m. to 10:04 a.m., a   | dated 06/06/21 to 06/19/21,<br>ked on 06/07/21 from 6:30<br>nd from 10:36 a.m. to 11:37<br>from 8:27 a.m. to 1:27 p.m.,<br>o 2:32 p.m.  |                     |  |                                   |                          |
|                          | The facility had documented the allegation was unsubstantited even through there was a witness, and failed to complete a thourgh investigation by interviewing other staff members and residents.   |   |                     |  |                                   |                          |
|                          | to describe her invest she would complete a and suspend staff, ta staff on the hall that the complete safe survey the section of the hall was asked if staff worstated not always. Stronsidered interviewi on other halls. She so other staff but not oth asked when the invest stated on 06/07/21 at when the investigation stated late on 06/07/2 thorough investigation stated, "I feel it was the | ng other staff and residents tated she has interviewed her residents. She was stigation was started. She at 10:00 a.m. She was asked he was completed. She he started she was asked if a he was conducted. She horough." She was asked if hessed after incident for |                     |  |                                   |                          |
|                          | 06/07/21. She stated lunch and when she is suspended and sent she worked on 06/08.  | CNA #2 had worked on I she left at 10:04 a.m. for returned, she was home. She was asked when /21. She stated she was neet with DON and watch  |                     |  |                                   |                          |

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Oklahoma State Department of Health

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | ` ′                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                                 |                          |
|--|---|---------------------|--|---------------------------------|--------------------------|
|  |   |                     |  |                                 | С                        |
|  | NH2407  | B. WING             |  | 07                              | /01/2021                 |
| NAME OF PROVIDER OR SUPPLIE  | R STREET AL   | DDRESS, CITY, STATE | , ZIP CODE   |                                 |                          |
| THE COMMONS  |   | TH OAKWOOD RO       | DAD  |                                 |                          |
| THE COMMONO  | ENID, OK  | 73706               |  |                                 |                          |
| PREFIX (EACH DEFIC   | RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ( OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| was asked what received. She stabout dementia, and two and a hawas asked what place to prevent residents. She stabout dementians asked what place to prevent residents. She stabout dependent because and she called the acknowledged stabout the incident in a stabout dependent of the incident i | en returned to the floor. She disciplinary actions CNA #2 ated she watched Relias video she was suspended on the 7th alf hours on the 8th. The DON corrective actions were put in further abuse and protect the tated there were no changes. she didn't feel the allegation se CNA #2 left the door open e CMA for help. She aff did not notify DON or ADM of imely manner.  Peport incident to the DON as a result, CNA #2 continued to esidents for approximately one and a half hours. A thorough a not completed by not r staff and residents. As a result, ther residents had been | LL244               |  |                                 |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE A. BUILDING:  | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED  |               |
|---|--|---|---------------------|--|---------------|
|   |  |   | A. BOILDING         |  | С             |
|   |  | NH2407  | B. WING             |  | 07/01/2021    |
| NAME OF F   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STAT  | TE, ZIP CODE   |               |
| THE COM   | IMONS  | 301 SOU   | TH OAKWOOD R        | ROAD   |               |
| THE CON   | INONS  | ENID, OF  | 73706               |  |               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETE |
| LL244   | Continued From page  | 92  | LL244               |  |               |
|   | On 06/28/21 at 5:20 a observed to be at the When approached, the a call that a resident I They were asked whe call. One stated, "Ab At 5:25 a.m., the adm talk to you guys." Sh lady who says she was the two ladies home."  An OSDH incident resident methodocumented, "Final of Abuse/Mistreatmer IncidentResident methodocumented by 50 pewas also saying we when staff CMA gave [signs/symptoms] of particular day and final reports, of the investigation | port, dated of 06/27/21,[Resident #8]Allegations ntDescription of akes allegation that she was ople every 30 minutes. She were trying to poison her her ultramNo S/S ohysical rape notedFor 5 please include a summary See attached  ate and time of report at 5:10 p.m., documented, orted perpetrator(s)A mWhat on of Rape and bed the to protect the resident(s) taff was to always go in that was done upon discovery and AdministratorWhat is physical done at 5PM |                     |  |               |

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|                          | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   |                     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|---|-------------------------------|
|                          |  |   | 7. BOILBING.        |   | С                             |
|                          |  | NH2407  | B. WING             |   | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, STA   | TE ZIP CODE   |                               |
| TO WILL OF T             | NOVIDEN ON GOL LEEN  |   | TH OAKWOOD I        |   |                               |
| THE COM                  | MONS   | ENID, OK  |                     |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE                   |
| LL244                    | Continued From page  | 93  | LL244               |   |                               |
|                          | began saying that the The bed was checked sign of bugs. She that she was raped. She allegations. She said woman and there is 5 She can not really de going in her room with being told by Adminis in with 2 Licensed number 12:32 p.m., documer #8] started yellingSi yelling rape. She said everyone has been ra  | o.m. to 11:15 p.m.] Resident are was bed bugs in her bed. If by 2 staff and found no an [sic] began saying that that the rapest [sic] is a coordinate of them every 5 minutes. Soribe themStaff has been a 2 people and then after tration we have been going |                     |   |                               |
|                          | A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly"  A statement, dated 06/28/21, from CMA #5 documented, "On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming"  On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she |   |                     |   |                               |
|                          |  |   |                     |   |                               |
|                          |  |   |                     |   |                               |

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STATE FORM 6899 C7JI11 If continuation sheet 94 of 227

Oklahoma State Department of Health

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  |                     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|--|---------------------|--|-------------------------------|--------------------------|
| ANDILAN                  | 32.11.10.110.110.110.110.110.11  |  | A. BUILDING: _      |  |                               |                          |
|                          |  | NH2407   | B. WING             |  | 07/0                          | 1/2021                   |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE   | -                             |                          |
| THE COM                  | MONS   | 301 SOUTH<br>ENID, OK  | I OAKWOOD F         | ROAD   |                               |                          |
|                          | OLIMAN DV OT   | ·  |                     | DDOUIDEDIO DI AN OF CODDECTIO  | .,                            |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL244                    | Continued From page  | 94   | LL244               |  |                               |                          |
|                          | told the nurse to go as<br>get a description of w<br>The nurse told the AD<br>female rapist and 50 p   | sk when it happened and hat the person looked like.  OM the resident reported a people every 30 minutes.  If the ADM that the rapist |                     |  |                               |                          |
|                          | The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.   |  |                     |  |                               |                          |
|                          | The ADM was asked how she proteceted the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No." |  |                     |  |                               |                          |
|                          | regarding resident #8  | allegation of rape was<br>M. She stated she based  |                     |  |                               |                          |

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|                          | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE A. BUILDING: | (X3) DATE SURVE<br>COMPLETED   | (X3) DATE SURVEY<br>COMPLETED |                        |
|--------------------------|--|---|----------------------------|--|-------------------------------|------------------------|
|                          |  |   | A. BOILDING.               |  |                               |                        |
|                          |  | NH2407  | B. WING                    |  | 07/01/20                      | 21                     |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD  | DRESS, CITY, STA           | TE, ZIP CODE   |                               |                        |
| TUE 001                  | MONO   |   | H OAKWOOD I                |  |                               |                        |
| THE COM                  | MONS   | ENID, OK  | 73706                      |  |                               |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE CO                      | (X5)<br>MPLETE<br>DATE |
| LL244                    | texted her that the resperpetrators as "looks investigative report do unable to give a desc "Yes", reffering to the She was asked if she discrepancies. She say." Reviewed her inshe stated the nurse of description the reside the report documente describe the perpetra given.  The two employees refacility all night after the resident identifying the who raped her.  The facility failed to he investigation into the second that the resident assessment documented the resident assessment documented the resident assessment documented the resident dated (#1 worked from 5:42 and A nurse's note, dated documented, "Resident back" | oM her interview from reported the charge nurse sident described the slike us" and that the ocumented the resident was ription. The ADM stated, discrepances in information. was concerned about the tated, "What does the report nerview from yesterday that reported to her the not stated "looks like us" and do the resident was unable to tor. There was no response the allegation of rape and the network and CNA as the ones are an accurate a through allegations.  agnoses which included  at, dated 02/15/21, lent's cognition was intact.  03/21/21, documented LPN a.m. to 3:21 p.m.  03/21/21 at 1:44 p.m., and observed on floor lying on the report, dated 03/21/21, documented unit of the report of the | LL244                      |  |                               |                        |
|                          | documented, "Alleg MistreatmentDescri  |   |                            |  |                               |                        |

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Oklahoma State Department of Health

|                          | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE (<br>A. BUILDING: | CONSTRUCTION  |           | E SURVEY<br>PLETED       |
|--------------------------|---|---|---------------------------------|---|-----------|--------------------------|
|                          |   |   |                                 |   | С         |                          |
|                          |   | NH2407  | B. WING                         |   | 07        | //01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STAT              | E, ZIP CODE   |           |                          |
|                          |   |   | TH OAKWOOD R                    |   |           |                          |
| THE COM                  | MONS  | ENID, OF  | 73706                           |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| LL244                    | director that activity a statement, that she of F****** Christ, [Reside notified he had fallen. The nurse is suspend complete" A facsim documented the repo 03/22/21 at 4:22 p.m.  There was no docume clinical record of the a resident.  The facility did not rept to the Oklahoma Stat within the required tw. A time record for LPN worked on 03/23/21 ft. A final OSDH report, at 6:38 p.m., docume day and final reports, of the investigationF investigation attached Safe surveys were coon 03/23/21. The foll asked:  1. Do you feel like whight, you get everythi 2. Have you heard stalanguage?  3. Has staff ever yelled. | or was notified by Activity ide reported to her in a verheard a nurse say "Jesus ent #6] really? when she was Nurse is not on shift today. Ided until investigation is hile (fax) cover sheet, rt was sent to the OSDH on entation in the resident's alleged abuse against the coort the allegation of abuse e Department of Health to hours.  I #1 documented she rom 5:42 a.m. to 2:34 p.m.  Ifaxed to OSDH on 03/23/21 anted the followingFor 5 please include a summary Face Sheet attached, d"  Inducted with three residents owing questions were then you turn on your calling you need taken care of? aff using inappropriate and or spoken harsh to you? | LL244                           | DEFICIENCY  |           |                          |
|                          | LPN #1 reamained w  | orking after the allegation of  |                                 |   |           |                          |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |      | JRVEY<br>ETED            |
|--------------------------|--|---|--|---|------|--------------------------|
|                          |  |   | _  |   | C    |                          |
|                          |  | NH2407  | B. WING                                  |   | _    | 1/2021                   |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STA                         | TE, ZIP CODE  |      |                          |
| THE COM                  | MONS   | 301 SOUT  | TH OAKWOOD F                             | ROAD  |      |                          |
| THE COM                  | WIONS  | ENID, OK  | 73706                                    |   |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETE<br>DATE |
| LL244                    | Continued From page  | 97  | LL244                                    |   |      |                          |
|                          | verbal abuse had bee invesitigation.   | n made and throughout the   |  |   |      |                          |
|                          | reporting staff member or other staff with the administrator docume the staff member maked others. She documented reported hearing the member who had maked if was reported to the staff member who had maked if was reported to the staff of t | anted that she had spoken to sing the allegation and three inted she spoke with resident the only person who comments was the staff de the allegation. The anted her conclusion was the staff de the allegation. The anted her conclusion was the source of the investigation was securentation was not. She lict between the activity aide as asked if LPN #1 had estigation. The DON as asked what was put in currence and to protect the lithere were no changes. The investigation was do a discussion about how on thave occurred. She was timely. She stated she was ext day. |  |   |      |                          |
|                          |  | She stated LPN #1 had<br>when she reported to her   |  |   |      |                          |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  |                     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|---|-------------------------------|
|                          |   |  |                     |   | C                             |
|                          |   | NH2407   | B. WING             |   | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, STA   | TE, ZIP CODE  |                               |
| THE COM                  | MONS  | 301 SOU  | TH OAKWOOD F        | ROAD  |                               |
| THE COM                  | INIOIAS   | ENID, OK   | 73706               |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE                 |
|                          | "Jesus F*** Christ, [R asked who she had restated she reported it and that her supervise administrator.  The facility failed to prinvestigation of abuse an allegation to the administration of abuse and agencies timely.  6. Resident #1 was and diagnoses which included   | ne stated, LPN #1 said, esident]. Really." She was eported the incident to. She to her supervisor that day or was going to call the rotect residents during an e, thourghly invesitgate an |                     |   |                               |
|                          | A state incident report form, dated 06/12/21, documented, "ResidentInvolved[resident #1]Incident TypeAllegations of Abuse/Mistreatment"  A notification of nurse aide report, dated 06/12/21, documented, "CNA #1was employee terminatedYestermination date 06/12/2021ALLEGATIONS/FACTS OF ABUSEOn June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1] |  |                     |   |                               |
|                          | was terminated for mi   | istreatment of a resident and<br>r Social Media Policy"  |                     |   |                               |

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| ` '                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1                   | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|---|-------------------------------|
|                          |   |  | 71. BOILBING.       |   | С                             |
|                          |   | NH2407   | B. WING             |   | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |                               |
| THE COM                  | MONS  |  | I OAKWOOD F         | ROAD  |                               |
|                          | T   | ENID, OK   | 73706               |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE                   |
| LL244                    | Continued From page   | 99   | LL244               |   |                               |
|                          | when were the staff ir phone use and social inserviced when they She was asked what media restrictions we anything about reside pictures. She stated cell phones in break rephone in resident are the staff were inservice. She stated they plant July. She stated they they had to wait for the updated policy. She measures were put in   | a.m., the DON was asked inserviced related to cell media. She stated they are are hired during orientation. the cell phone and social re. She stated not to post ents, the facility and no staff were only to have their from and not to have a cell as. The DON was asked if ced related to the incident. The don inservicing staff in a were going to in June but their board's approval of the was asked if any corrective a place to protect the roccurrence. She stated |                     |   |                               |
|                          | they weren't.  On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions.  A thorough investigation had not been completed related to this incident. As a result, it is unknown if any other staff or residents had been involved.  7. A grievance concern form, dated 07/24/20, documented, "Person Filing Complaint[CMA #4]Nature of the ConcernWeekend staff would yell at [Resident] when she came out of her room to go back, would walk her back, close her |  |                     |   |                               |

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|                          | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   |                     | (X2) MULTIPLE CONSTRUCTION   |         |                          |
|--------------------------|---|---|---------------------|--|---------|--------------------------|
|                          |   |   | A. BUILDING:        |  |         | PLETED                   |
|                          | NH2407  |   | B. WING             |  | 07      | C<br>/ <b>01/2021</b>    |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STAT  | E ZIP CODE   |         |                          |
| NAME OF T                | NOVIDEN ON GOLF EIEN  |   | TH OAKWOOD R        |  |         |                          |
| THE COM                  | MONS  | ENID, OK  |                     | OAD  |         |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETE<br>DATE |
| LL244                    | door after she went in couldn't open it. She the Med [medication] yanked it around [and When [CMA #4] said [and] retaliated agains.  Staff Assigned to InvestigateADON] 2-10 shift for 7/19/20 to confirm the above nurse and she stated her and when [reside they put a mask on he goResolution[CM discuss her allegation didn't back those allegemployee warning for misrepresentation 2) manner contrary to remorality [and] decendence oncern form]When [in refused to do anything F words. Would throw make [CMA #4] pick the every weekend she hincident happened on anonymouswants to An employee warning documented, "EMP event07/24/2020F TDishonesty [and] material information-stdayACTION TAKEN #1SUSPENSION" | a [and] hold the door so she eventually came out again, aide grabbed her walker, if said "I'm tired of this shit. anything, she was bullied st  InvestigationWatched the on camera and saw nothing complain. I talked to the no issues were reported to into comes out of her room, er and let her A#4] was called in to is. Was informed the video gations up. She received an oral dishonesty, conducting one self in a ecognized standards of ey[On the back of the CMA #4] told the nurse, she is generally generally generally as workedThis specific is a workedThis worked"  In notice, dated 07/27/20, LOYEE [CMA#4]Date of PROBLEM/EVENT/INCIDEN misrepresentation about suspension of one willWRITTEN WARNING | LL244               |  |         |                          |
|                          |   | d dishonesty as a direct allegation of verbal abuse   |                     |  |         |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |               |
|---|---|--|--|--|---------------|
|   |   |  | 756.256.                                 |  | C             |
|   |   | NH2407   | B. WING                                  | <del></del>  | 07/01/2021    |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STAT                       | E, ZIP CODE  |               |
| THE COM   | MONS  | 301 SOU  | TH OAKWOOD R                             | OAD  |               |
| THE COM   | WONS  | ENID, OF   | 73706                                    |  |               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETE |
| LL244   | Continued From page   | : 101  | LL244                                    |  |               |
|   | against her co-worker   | S.   |  |  |               |
|   | staff reported suspect they reported it to the their chain of comman months ago, a resider abuse to her and ano DON was busy testing meeting so they went She stated they were chain of command. So reported to if the DON stated they can alway phone. | a.m., LPN #3 was asked who ded abuse to. She stated DON because that was and. She stated, about three and had reported verbal ther nurse. She stated the group staff, the ADM was in a to the admin's assistant. It told they had to go to their the was asked who they was not in the facility. She are reach her on her the cell |  |  |               |
|   | she witnessed abuse month or two ago and She was asked when She stated staff typica of command but the pabuse was her chain to state the incident with She was asked if she   | a.m., CMA # 3 was asked if She stated she did a I she reported it to the ADM. and who did she report to. ally report through the chain berson who had done the of command. She went on was "traumatizing to me." was afraid to report abuse. worried that someone would  |  |  |               |
|   | she had ever felt like incidents of allegation "Yeah." She stated, "\done." She stated, "\be more in trouble for At 3:09 p.m., the activ  | s of abuse. She stated, Sometimes things don't get We feel like people should certain things."   |  |  |               |
|   | of abuse. She stated  | could not report allegations<br>, "Honestly, yes." She<br>ported to her [ADM], she   |  |  |               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE  | (X3) DATE SURVEY<br>COMPLETED |   |                 |
|---|--|--|-------------------------------|---|-----------------|
|   |  |  | A. BUILDING: _                |   |                 |
|   |  | NH2407   | B. WING                       |   | C<br>07/01/2021 |
| NAME OF PI  | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA               | TE, ZIP CODE  |                 |
| THE COM   | MONS   |  | OAKWOOD F                     | ROAD  |                 |
|   |  | ENID, OK   | 73706                         |   |                 |
| (X4) ID<br>PREFIX<br>TAG  |  |  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE     |
| LL244   | 14 Continued From page 102   |  | LL244                         |   |                 |
|   | #1 and ADM were ask investigation related to 07/24/20. SS#1 state from CMA #4.  The ADM stated the Athe cameras for the 0 was for one shift. She whole day. She was athoroughly investigate.  They were asked if Claction. The ADM state | o.m., the Social Services[SS] ked to describe the to the grievance form dated and she took the statement  ADON and herself looked at 7/19/20. She was asked if it to stated they looked at the asked if the incident was and. The ADM stated, "No."  MA #4 received disciplinary and, "Yes." She was asked               |                               |   |                 |
|   | The ADM stated in he ADON] thought CMA from what she remem ADON] thought it was stated she argued wit because, in her opinion the staff member. She remain anonymous.  On 06/29/21 at 7:02 pshe was fearful of rep She stated, "Yes and  | N and ADON had decided. Fr opinion, they [DON and #4 was lying. SS#1 stated, abered, they [DON and a fraudulent report. SS#1 h them [DON and ADON] on, it was retaliation against e stated CMA #4 wanted to on., CMA #3 was asked if orting allegations of abuse.  No." She stated if LPN #3 aid she'd come back at me." |                               |   |                 |
| LL610   | 310:675-7-5.1(b) Rep misappropriation  The facility shall report allegations and incide neglect or misappropriation  | orting abuse, neglect or   | LL610                         |   |                 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|---------------------|---|-------------------------------|--------------------------|
|   |  |  | A. BOILDING         | <del></del>   |                               |                          |
|   |  | NH2407   | B. WING             |   | 07/0                          | 1/2021                   |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |                               |                          |
| THE COM   | MONS   |  | OAKWOOD F           | ROAD  |                               |                          |
| 1112 00111  | MICINO   | ENID, OK   | 73706               |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL610   | Continued From page  | 103  | LL610               |   |                               |                          |
|   | not supersede reporti<br>of the Oklahoma Stati<br>Protective Services fo<br>Incapacitated Adults A   | ng requirements in Title 43A<br>utes (relating to the<br>or the Elderly and for<br>Act).   |                     |   |                               |                          |
|   | facility's failure to ens allegations of abuse in  | ediate Jeopardy (IJ)<br>ned to exist related to the  |                     |   |                               |                          |
|   | A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator for investigation. |  |                     |   |                               |                          |
|   | An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured.                                  |  |                     |   |                               |                          |
|   | being physically abus<br>reported by staff. The<br>resident, complete a t  | ed an incident of resident #5 ed by staff witnessed and e facility failed to protect the horough investigation and measures to prevent further |                     |   |                               |                          |
|   | an employee and repo   | I abuse to Resident #6, by orted it to the charge nurse. not report the allegation to ly.  |                     |   |                               |                          |
|   |  | ahoma State Department of otified and verified the uation.   |                     |   |                               |                          |
|   | At 11:28 a.m., the Adr<br>notified of the IJ.  | ministrator (ADM) was  |                     |   |                               |                          |

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|                          | FOF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | (X2) MULTIPLE C      | ONSTRUCTION  |                                   | E SURVEY<br>PLETED       |
|--------------------------|--|--|----------------------|--|-----------------------------------|--------------------------|
|                          |  |  | A. BUILDING:         |  |                                   |                          |
|                          |  |  | 5 11/11/0            |  |                                   | С                        |
|                          |  | NH2407   | B. WING              |  | 07                                | 7/01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A   | ADDRESS, CITY, STATE | , ZIP CODE   |                                   |                          |
|                          |  |  | JTH OAKWOOD RO       |  |                                   |                          |
| THE COM                  | MONS   |  | K 73706              | ,,,,,,   |                                   |                          |
| 0(1) 15                  | CHMMADV CT   | ATEMENT OF DEFICIENCIES                                    |                      | PROVIDER'S PLAN OF                                     | CORRECTION                        | 0/5)                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL610                    | Continued From page  | e 104  | LL610                |  |                                   |                          |
|                          | An accentable plan o   | f removal was provided by                                  |                      |  |                                   |                          |
|                          |  | 06/25/21 at 9:55 p.m. It                                   |                      |  |                                   |                          |
|                          | documented the follo   |  |                      |  |                                   |                          |
|                          |  | 9.   |                      |  |                                   |                          |
|                          | "All residents will be i   | interviewed 06/25/2021. All                                |                      |  |                                   |                          |
|                          | staff on shift will be e   | ducated on updated policy                                  |                      |  |                                   |                          |
|                          | immediately, and if no   | ot currently working will be                               |                      |  |                                   |                          |
|                          | inserviced by phone  |  |                      |  |                                   |                          |
|                          | ,  | iched) (amended to be 9 am                                 |                      |  |                                   |                          |
|                          | on 06/26/2021)  ** if unable to be contacted, we will document date and time, and the staff member will be taken |  |                      |  |                                   |                          |
|                          |  |  |                      |  |                                   |                          |
|                          | off the schedule until   |  |                      |  |                                   |                          |
|                          | The following texts w  | •  |                      |  |                                   |                          |
|                          |  | ors have identified serious                                |                      |  |                                   |                          |
|                          |  | reporting. All staff are                                   |                      |  |                                   |                          |
|                          |  | in-service. Someone from                                   |                      |  |                                   |                          |
|                          |  | e calling you before midnight                              |                      |  |                                   |                          |
|                          | tonightIf you have b   | peen not contacted to                                      |                      |  |                                   |                          |
|                          | complete an in-service   | ce by midnight, call [director                             |                      |  |                                   |                          |
|                          | of nursing] or will be a   |  |                      |  |                                   |                          |
|                          |  | IMMEDIATELY-reporting of                                   |                      |  |                                   |                          |
|                          |  | ns will be need to be texted                               |                      |  |                                   |                          |
|                          | or called to [administ   |  |                      |  |                                   |                          |
|                          | _  | s any time- DAY or NIGHT!<br>ext, then CALLAll staff that  |                      |  |                                   |                          |
|                          |  | as not timely reporting abuse                              |                      |  |                                   |                          |
|                          |  | suspension. [Resident #5]                                  |                      |  |                                   |                          |
|                          |  | hysical abuse allegation will                              |                      |  |                                   |                          |
|                          | ·  | liately. At every allegation of                            |                      |  |                                   |                          |
|                          | abuse, a text will be s  | sent to all staff to remind                                |                      |  |                                   |                          |
|                          |  | ise very seriouslyAn                                       |                      |  |                                   |                          |
|                          |  | eported, this is a reminder                                |                      |  |                                   |                          |
|                          |  | rill be tolerated Administrator,                           |                      |  |                                   |                          |
|                          |  | nd DON have learned that a                                 |                      |  |                                   |                          |
|                          |  | n includes resident safe                                   |                      |  |                                   |                          |
|                          | _  | nat the alleged abuser has                                 |                      |  |                                   |                          |
|                          |  | statements from those                                      |                      |  |                                   |                          |
|                          | We have reviewed th  | e included in an investigation.                            |                      |  |                                   |                          |

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| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73766  CM/ID PREFIX TAG  SUMMARY STATEMENT OF DESTIGATIONS  SUMMARY STATEMENT OF DESTIGATIONS (EACH CORRECTIVE ACTION SHOULD BE COMMENTED BY YOUL SECOND STYLLL REGULATORY OR LSC IDENTIFYING INFORMATION)  LL610  Continued From page 105  examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the vintess is the person that has reported the incident during the investigation. We learned that to prepriy assess the resident we must conduct medical, psychosocial, and mental status assessment each shift for 3 days for 9 occurrences*  On 06/28/21, six nurse aides (CMA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.  At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administration forums online. She was asked if there was anything specific rouns online. She was asked if there was anything specific they educated the administrative staff on She stated, TNo, nothing specific.  At 3.30 p.m., the administrator was made aware that an amended plan of removal was needed             | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X2) |   | (X3) DATE SURVEY<br>COMPLETED     |          |
|---|---|---|---|---|---|-----------------------------------|----------|
| NAME OF PROVIDER OR SUPPLIER  THE COMMONS  SUMMARY STATEMENT OF DEFICIENCIES ENDI, OK 73706  PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  LL610  Continued From page 105  examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the viness is the person that has reported the incident during the investigation. We learned that the vinese process of contribution of the property assess the resident we must conduct medical, psychosocial, and mental status assessment each shift for 3 days for 9 occurrences."  On 06/28/21, isk nurse aides (CNA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.  At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrative staff. She stated they looked up information mental the state operations manual and reached out to some of her administrative staff. She stated they looked up information themselves. She was asked if she shared that information with her administrative staff on. She stated, "No, nothing specific."  At 3:30 p.m., the administrator was made aware |   |   |   | A. BOILDING.                                  |   |                                   | C        |
| CALL DISTRICT   CALL DEFICIENCY MIST BE PRECEDED BY FULL   CROSS-REFERENCED TO THE APPROPRIATE   DATE   |   |   | NH2407  | B. WING                                       |   | 07                                | -        |
| SUMMARY STATEMENT OF DEFICIENCIES   DEFORMATION   | NAME OF P   | ROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, STATE                           | , ZIP CODE                                    | -                                 |          |
| (X4) ID SIMMARY STATEMENT OF DEFICIENCES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  LL610  Continued From page 105  examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9 occurrences*  On 06/28/21, six nurse aides (CNA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.  At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrative forours online. She was asked if she shared that information with her administrative rows as sked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific."  At 3:30 p.m., the administrator was made aware  | THE COM   | MONE  | 301 SOU   | TH OAKWOOD RO                                 | )AD   |                                   |          |
| CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   TAG  | THE COM   | MONS  | ENID, OK  | 73706   |   |                                   |          |
| examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9 occurrences"  On 06/28/21, six nurse aides (CNA), seven certifled medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.  At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrator forums online. She was asked if she shared that information with her administrative staff. She stated they looked up information themselves. She was asked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific."  At 3:30 p.m., the administrator was made aware  | PREFIX  | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL  | PREFIX  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1 | TION SHOULD BE<br>THE APPROPRIATE | COMPLETE |
| due to ongoing abuse and neglect allegations not being reported timley, not rotecting residents and conducting thorough investigations.  An acceptable plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It  | LL610   | examples of abuse at that have been updat staff members on the learned that the witner reported the incident learned that to proper must conduct medical status assessment at assessment each shi occurrences.  On 06/28/21, six nursicertified medication a practical nurses (LPN (RN), seven houseke maintenance staff frointerviewed and able related to abuse.  At 6:57 a.m., the ADN did to further educate abuse. She stated shoperations manual arrher administrator foruif she shared that information themselve was anything specific administrative staff. Sinformation themselve was anything specific administrative staff or specific."  At 3:30 p.m., the admithat an amended plar due to ongoing abuse being reported timley conducting thorough.  An acceptable plan of | and will follow our policies ed. We will in-service all attached education. We ass is the person that has during the investigation. We rly assess the resident we I, psychosocial, and mental the time, and an fit for 3 days for 9  The aides (CNA), seven ides (CMA), six licensed I), one registered nurse epers and one m across all shifts, were to state accurate information  If was asked what the facility the administrative staff on the looked through the state and reached out to some of tims online. She was asked formation with her She stated they looked up the stated the they educated the they educated the they educated the they end removal was needed the and neglect allegations not the not rotecting residents and dinvestigations.  If removal was provided by | LL610   |   |                                   |          |

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STATE FORM 6899 C7JI11 If continuation sheet 106 of 227

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` '  | (X2) MULTIPLE CONSTRUCTION ( |   |           |                          |
|---|---|--|------------------------------|---|-----------|--------------------------|
| AND FLAIN   | OF CORRECTION   | IDENTIFICATION NOWBER.   | A. BUILDING:                 |   | COM       | PLETED                   |
|   |   |  | D WING                       |   |           | С                        |
|   |   | NH2407   | B. WING                      |   | 07        | /01/2021                 |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STATE          | , ZIP CODE  |           |                          |
| TUE 001   | MONO  | 301 SOU  | TH OAKWOOD RO                | AD  |           |                          |
| THE COM   | MONS  | ENID, O  | <b>K</b> 73706               |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| LL610   | Continued From page   | e 106  | LL610                        |   |           |                          |
|   | 2021 [By 8:00 p.m.] Misappropriation InveupdatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the ADON [assistant directoutside agency. Due 06/28/21 [staff name  | completed by June 30th,<br>Abuse, Neglect,<br>estigation POLICY was  |                              |   |           |                          |
|   | the INCIDENT RESP and includes the Adm Administrator, DON, A Center Resident serv administrator or design Director any allegation scheduled monthly mander of the Incident of | ADON, and HealthCare ices Director. The gnee will report to Board of n of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ng, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and is to ensure all thorough n completed." |                              |   |           |                          |
|   | were interviewed and information related to   | Ns, one RN and three CMAs able to state accurate abuse and neglect and five ere interviewed and were   |                              |   |           |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 107 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:      |  |          |
|---|---|--|---|--|----------|
|   |   |  | A. Boilebino.                                 |  |          |
|   |   | NH2407 B. WING   |   | C<br><b>07/01/2021</b>   |          |
| NAME OF D   |   | etdeet A   | DDDESS CITY STATE                             | ZID CODE   |          |
| NAME OF P   | ROVIDER OR SUPPLIER   |  | ddress, city, state<br>I <b>TH OAKWOOD R(</b> |  |          |
| THE COM   | THE COMMONS ENID, OK  |  |   | JAD  |          |
| (X4) ID   | SUMMARY STA   | ATEMENT OF DEFICIENCIES  | ID  | PROVIDER'S PLAN OF CORRECT   | TON (X5) |
| PRÉFIX<br>TAG   |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                                 | (EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |          |
| LL610   | Continued From page   | : 107  | LL610   |  |          |
|   | able to state accurate abuse and neglect.   | information related to   |   |  |          |
|   | of 06/30/21 at 5:10 p.i<br>plan of removal and the<br>had been implemente   | rdy deficiency was lifted as<br>m. when all elements of the<br>ne amended plan of removal<br>d. The deficient practice<br>factual harm at a pattern.                       |   |  |          |
|   | Based on record review, resident and staff interviews, it was determined the facility failed to ensure staff reported allegations of abuse immediately after identifying abuse/suspected abuse had occurred for four (#5, 6, 7 and #9) of six sampled residents reviewed for abuse.   |  |   |  |          |
|   | The facility identified 95 residents resided in the facility.   |  |   |  |          |
|   | Findings:   |  |   |  |          |
|   | "Reporting Requiremereported immediately and to other officials in law. Allegations that is reported within 2 hour be thoroughly investig further potential abuse progressappropriate including report to the boardPreventionIt Commons that each rabuse, neglectAll faupon first employmen thereafter, regarding abuseImmediately rabuse, neglect or mis | [sic] the policy of The esident will be free from cility staff will be in-serviced t, and at least annually .neglect or eport any suspicion of treatment to your immediate |   |  |          |
|   |   | ervisor WILL CALL the CELL<br>STRATOR [admin], then the  |   |  |          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | . ,  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|---|--|-------------------------------|--------------------------|
|   |  |  |   |  |                               |                          |
|   |  | NH2407   | B. WING                                 |  | 07/01                         | 1/2021                   |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA                         | TE, ZIP CODE   |                               |                          |
| THE COM   | MONS   |  | I OAKWOOD F                             | ROAD   |                               |                          |
| ENID, OK  |  | ·  |   | DROWDERIO DI ANI OF CORRECTIO  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL610   | Continued From page  | e 108  | LL610                                   |  |                               |                          |
|   | DONSuspected or also be reported to re state agencies, law er families, and/or reside subject of abuse shal discussedInvestigat for, treat and PROTE ADON, or house superassessment immedia in detailTake a state resident2ndIsolateImmediately notify to" | substantiated cases must spective agencies such as inforcement, physician; ent responsible party. The I be routinely and openly tionProcedure1stCare CT the resident-DON, ervisor should do a medical telydocumenting any injury ement from the ethe perpetrator3rd he Administrator, then DON |   |  |                               |                          |
|   | Resident #9 had diagnoses which included chronic pain and osteoarthritis.  |  |   |  |                               |                          |
|   | A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.  |  |   |  |                               |                          |
|   | "Resident is at risk muscle spasms and c syndromeResident  | chronic pain<br>will have pain<br>imely mannerAdminister   |   |  |                               |                          |
|   | "hydrocodone 7.5 mg<br>325 mg tablet (Norco  | ated 06/08/21, documented,<br>[milligrams]-acetaminophen<br>) give 1 tablet by oral route<br>ded FOR CHRONIC PAIN  |   |  |                               |                          |
|   | Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain   |  |   |  |                               |                          |
|   | Ultram 50 mg tablet g<br>route every 6 hours a   | ive 1 tablet (50 mg) by oral<br>s needed for pain"   |   |  |                               |                          |
|   | A statement from CM  | A #3, dated 06/26/21 at  |   |  |                               |                          |

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|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | CONSTRUCTION   | (X3) DATE S |                          |
|--------------------------|--|---|---------------------|--|-------------|--------------------------|
|                          |  |   | A. BOILDING         |  |             | ,                        |
|                          | NH2407 B. WING   |   |                     | 1  | )<br>1/2021 |                          |
| NAME OF PI               | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE   |             |                          |
| THE COM                  | MONS   |   | I OAKWOOD F         | ROAD   |             |                          |
| 040.15                   | STIMMADA ST  | ENID, OK  |                     | PROVIDER'S PLAN OF CORRECTION  | NI.         | 0/5)                     |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE          | (X5)<br>COMPLETE<br>DATE |
| LL610                    | Continued From page  | e 109   | LL610               |  |             |                          |
|                          | on multiple occasions thing in the morning a [Resident #9] get up of ask for a pain pill. He Norco and rate his pabutt pain. As protoco request to the charge go to the resident to e report back to me, the administer a pain melevel of the pain that location of th [sic] pai [LPN #3], will deny the name], pain meds stated doesn't need a pain pamoke a cigarette, he he can go outside to pain pill because he hon these occurances | n. On many occurrences, e resident, [Resident's ting 'He just got up, he ill' or 'He's going outside to 's not hurting bad enough if smoke' or 'He can't have a nasn't eaten anything yet.' , [Resident] won't receive times 10 a.m or as late a 2 he MAR [medication |                     |  |             |                          |
|                          | Abuse/Mistreatment   | dent #9]Allegations of<br>.Description of<br>ed Nurse not approving PRN<br>dent asked for them.   |                     |  |             |                          |
|                          | 12:23 [did not docum<br>documented, "Somet<br>pills when it is not tim<br>is scheduled [every] &<br>offered Tylenol if Nord  | N #3, dated 06/27/21 at ent a.m. or p.m.], imes resident asks for pain e as he had it earlier. Med B [hours] prn. Resident is co can't be given yet"  |                     |  |             |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` '  | (X2) MULTIPLE CONSTRUCTION (X3 |   |                              |                          |
|---|---|--|--------------------------------|---|------------------------------|--------------------------|
|   |   |  | A. BUILDING:                   | A. BUILDING:  |                              |                          |
|   |   | NH2407   | B. WING                        |   | 07                           | C<br>7 <b>/01/2021</b>   |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STATE            | E, ZIP CODE   |                              |                          |
| THE COM   | MONS  | 301 SOU  | TH OAKWOOD RO                  | DAD   |                              |                          |
| THE COM   | WONS  | ENID, OF   | C 73706                        |   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL610   | Continued From page   | e 110  | LL610                          |   |                              |                          |
|   | The questions asked to the residents were not related to receiving pain medications.  |  |                                |   |                              |                          |
|   | The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.  The employee continued to work during the investigation of the alleged negelct.  The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld.  |  |                                |   |                              |                          |
|   |   |  |                                |   |                              |                          |
|   |   |  |                                |   |                              |                          |
|   | assistant administrator conclusion of the investad administrator stated is spreadsheet of which versus the Norco. She had administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it withheld the medicatic conclusion the allegal She stated she went in the same of the stated she went in the same of the | times the resident had She stated she didn't think had requested it. She was documentation of when the had the CMA stated LPN #3 hon, how did they come to the hion was unsubstantiated. https://documentation.org/li> |                                |   |                              |                          |
|   | There were no questi<br>related to staff withho<br>stated the executive of<br>surveys and thought   | If provided resident surveys.  ons asked to the residents Iding pain medications. She director had made the that the question "Do staff or requests and allow you to   |                                |   |                              |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 111 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | , ,  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED  |                          |
|---|--|--|--|--|--------------------------------|--------------------------|
|   |  |  | 7.1. 20.125101                           |  |                                | С                        |
|   |  | NH2407   | B. WING                                  | <del></del>  | 07                             | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, STATE                      | E, ZIP CODE  |                                |                          |
| THE COM   | IMONS  |  | TH OAKWOOD RO                            | DAD  |                                |                          |
| ENID, O   |  | ENID, OF   | C 73706                                  |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL610   | Continued From page  | e 111  | LL610                                    |  |                                |                          |
|   | make decisions regar<br>that.  | ding your care" covered  |  |  |                                |                          |
|   | if he was in pain. He right side, leg and know rate it at an 8 out of 1 a 9 in the mornings. he did not get his Nor He stated, "If I don't gwas asked if his Nord stated it was and ther | o.m., the resident was asked stated he had pain in his ee. She stated he would 0. He stated it was usually He was asked how he felt if roo when he requested it. get them, I get mad." He so was ever withheld. He in stated he would not bloyee was that withheld the   |  |  |                                |                          |
|   | allegations made reginer. She stated, "I the time." She stated because when he ask protocol I have to followould give the same in her statement. She take their pain as the              | was asked about the arding LPN #3 withholding Norco is what he asks for all I, "It's upsetting to me as for something, I have ow." She stated that LPN #3 responses CMA #3 had put the stated she was taught to by stated it. She stated LPN Iminister Tylenol or Ultram |  |  |                                |                          |
|   | Resident #7 was a diagnoses which incluanxiety disorder.   | dmitted to the facility with uded convulsions and  |  |  |                                |                          |
|   |  | ssessment, dated 02/18/21,<br>dent's cognition was severely  |  |  |                                |                          |
|   | documented, "Incid<br>Abuse/Mistreatment<br>IncidentAdministrat  | t form, dated 02/23/21,<br>ent TypeAllegations of<br>.Description of<br>or was notified today of an<br>buse occurring on 02/22/21  |  |  |                                |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 112 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                   | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|---|--|-------------------|---|-----------------|
|   |   |  | A. BOILDING.      |   |                 |
|   |   | NH2407   | B. WING           |   | C<br>07/01/2021 |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STA | TE ZIP CODE   |                 |
| TO THE OT T   | NOVIDEN ON OUT FEEL   |  | TH OAKWOOD F      |   |                 |
| THE COM   | MONS  | ENID, OK   |                   | (OAD  |                 |
| (X4) ID   | SUMMARY STA   | ATEMENT OF DEFICIENCIES  | ID                | PROVIDER'S PLAN OF CORRECTIO  | N (X5)          |
| PREFIX<br>TAG   |   |  | PREFIX<br>TAG     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE     |
| LL610   | Continued From page   | : 112  | LL610             |   |                 |
|   | is not on the schedule not be working until the investigated. Investig day and final reports, of the investigatione implemented to preveattached for investigaresident. She was su ways to recognize but Employee Assistance. The allegation of abus administrator until the The facility failed to rewithin two hours to the   | tion: Nurse yelled at<br>spended and counseled on<br>rnout. Also gave her  |                   |   |                 |
|   | documented, "The da spent a majority of the hallway outside of [an approximately 2 p.m. himself in his wheelch station area and park outside of the wound Immediately the chargand yelled to [residen here, you're not going here." [Resident #7] yelled at [LPN #3]. It is to health conditions. again "get the hell out talk to me that way." [resident #7] wheeled nurse's station area by | nair up closer to the nurse's ed himself in his wheelchair care nurse's office. ge nurse, [LPN #3], stood up t #7] "get the hell out of to sit up here while I'm did raise his hands and do not know what he yelled offen hard to make out due [LPN #3] then yelled at him to fhere, you're not going to |                   |   |                 |

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STATE FORM 6899 C7JI11 If continuation sheet 113 of 227

Oklahoma State Department of Health

|                          | FOF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|----------------------------|---|-------------------------------|
|                          |  |  | A. BOILDING                |   |                               |
|                          |  | NH2407   | B. WING                    |   | C<br>07/01/2021               |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STAT         | TE ZIP CODE   | •                             |
| TVAINE OF T              | NOVIDEN ON GOLT EIEN   |  | TH OAKWOOD R               | •   |                               |
| THE COM                  | MONS   | ENID, OF   |                            |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETE              |
| LL610                    | Continued From page  | e 113  | LL610                      |   |                               |
|                          | sitting in a chair besidentire event"  | le me and witnessed the  |                            |   |                               |
|                          | documented, "On Mo #4] came into work I was station at nurses station (LPN # around and go back had a said I dont care Im not and he said he wanted screamed at him and your [sic] not sitting undeal with your Ass. so Corner til [LPN #3] let of the evening"  A written statement be documented, "The ottoring work into work in the statement be documented, "The ottoring work in the work into work in the work into work in the work into | said "I dont give a dam [sic] p here Im not gonna [sic] p [resident #7] sat in the ft he was very upset the rest  y CNA #3, dated 02/24/21, her day I was in the office                    |                            |   |                               |
|                          | at [resident #7]. And<br>[Resident #7] started<br>#3] got louder and tol   | en I heard [LPN #3] yelling telling him to go to his room. yelling back at her and [LPN d him she wasn't going to r room. [LPN #3] then said like this"                                    |                            |   |                               |
|                          | "When did the incid<br>on Feb [February] 22  | ary, undated, documented,<br>ent happenAround 2pm<br>ndWhen was facility<br>nent staff first contacted<br>on Feb 23rd"   |                            |   |                               |
|                          | who the staff could re<br>She stated, "Any auth<br>the staff had witnesse<br>timely. She stated, "I<br>staff who witnessed the   | o.m., the admin was asked eport suspected abuse to nority." She was asked when ed the abuse, did they report No." She was asked if the he abuse were inserviced or She stated, "Nothing in |                            |   |                               |

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STATE FORM 6899 C7JI11 If continuation sheet 114 of 227

Oklahoma State Department of Health

|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|---|-------------------------------|
|                          |   |  | A. BUILDING: _      |   |                               |
|                          |   | NH2407   | B. WING             |   | C<br><b>07/01/2021</b>        |
|                          |   | NH2407   |                     |   | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STAT  |   |                               |
| THE COM                  | MONS  |  | TH OAKWOOD R        | ROAD  |                               |
|                          | T   | ENID, OF   | 73706               |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JLD BE COMPLETE               |
| LL610                    | Continued From page   | e 114  | LL610               |   |                               |
|                          | writing."   |  |                     |   |                               |
|                          | verbal abuse happen p.m. She stated "Yes continued to work after was asked if LPN #3 residents, how were the stated," They couldn't about it." She was as report the abuse immediated. She stated. The staff members when the immediately report worked with the victin approximately four hor continued in the staff members where the staff members | ho witnessed the abuse did<br>rt it. As a result, LPN #3<br>n and other residents for<br>ours and 48 minutes.<br>dmitted to the facility with                                    |                     |   |                               |
|                          | documented the resid  | ssessment, dated 05/02/21,<br>dent's cognitive skills for<br>was severely impaired.  |                     |   |                               |
|                          | documented, "Resider #5]Incident TypeA<br>Abuse/Mistreatment<br>IncidentReceived a<br>towards a resident by   | .Description of<br>n allegation of abuse   |                     |   |                               |
|                          | #2] asked me if I coul<br>yes just give me a se<br>middle of taking care<br>I walked into [residen  | om CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had t arm yanking [and] pulling |                     |   |                               |

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STATE FORM 6899 C7JI11 If continuation sheet 115 of 227

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|                          |  |   | (X3) DATE SURVEY<br>COMPLETED |   |               |
|--------------------------|--|---|-------------------------------|---|---------------|
|                          |  | NUO407  | B. WING                       |   | C             |
|                          |  | NH2407  | B. W. TO                      |   | 07/01/2021    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STA             | TE, ZIP CODE  |               |
| THE COM                  | MONS   |   | TH OAKWOOD F                  | ROAD  |               |
|                          | T  | ENID, OF  | 73706                         |   |               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE |
| LL610                    | Continued From page  |   | LL610                         |   |               |
|                          | bare skin I yelled at way [and] she was lik dropped him back on his arm to get him up would take care of hir breakfast [and] told th just happened. Wher #2] she told her to sta [resident #5]. When I [10:00 a.m.] I asked if [and] I told [DON] what me she was not awar asked me to write out.  A written statement for documented, "[CMA # yelled at [CNA #2] be me to help get him [resort where she was at her states she saw. | slapping at his left leg,-on ther to stop doing him that e what [and] just kind of the bed, she went to pull on I told her to just leave that I m. I brought him out for the Charge Nursewhat had the [LPN #2] talked to [CNA the sy away from direct care of the seen [sic] D.O.Naround for [LPN #2] had talk to her talk that happened She told the but now she is [and] that a statement"  The same to me and stated "I cause she came out to ask the sident #5] up I went into the and he was mad and hitting ther grab his arm and swat her to leave and I would |                               |   |               |
|                          | finish him, I went to [0 happened she said I   | CNA #2] and asked what was just playing and I would as told by nurse to stay out of   |                               |   |               |
|                          | "When did the incid<br>a.m.]When was faci  | nent staff first contacted  |                               |   |               |
|                          | On 06/24/21 at 12:48 acknowledged staff dithe incident in a timel  | id not notify DON or ADM of   |                               |   |               |
|                          |  | incident to the DON result, CNA #2 continued to ents for approximately one  |                               |   |               |

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|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE       | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|--|-------------------------------|
| AND PLAN (               | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDING: _      | A. BUILDING:   |                               |
|                          |  |   | B. WING             |  | С                             |
|                          |  | NH2407  | B. WING             |  | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE   |                               |
| THE COM                  | MONS   |   | I OAKWOOD F         | ROAD   |                               |
|                          |  | ENID, OK  |                     |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE                   |
| LL610                    | Continued From page  | e 116   | LL610               |  |                               |
|                          | and a half to two and  | a half hours.   |                     |  |                               |
|                          | 4. Resident #6 had di<br>Huntington's disease.   | agnoses which included  |                     |  |                               |
|                          | A resident assessment documented the resident  | nt, dated 02/15/21,<br>lent's cognition was intact.   |                     |  |                               |
|                          |  | 03/21/21 at 1:44 p.m.,<br>ent observed on floor lying on  |                     |  |                               |
|                          | documented, "Alleg MistreatmentDescri IncidentAdministrat director that activity a statement, that she of F***** Christ, [Reside notified he had fallen. The nurse is suspend complete" A facsim documented the repo 03/22/21 at 4:22 p.m. | ption of or was notified by Activity ide reported to her in a verheard a nurse say "Jesus ent #6] really? when she was Nurse is not on shift today. led until investigation is nile (fax) cover sheet, rt was sent to the OSDH on |                     |  |                               |
|                          | was reported timely. notified until the next   | She stated she was not day.   |                     |  |                               |
|                          | asked who she had re<br>stated she reported it   | a.m., the activity aide was eported the incident to. She to her supervisor that day or was going to call the  |                     |  |                               |
|                          |  |   |                     |  |                               |

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|               | OF DEFICIENCIES<br>OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:          | ' '              | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|---------------|--|---|------------------|---|-------------------------------|
|               |  |   |                  |   | c                             |
|               |  | NH2407  | B. WING          |   | 07/01/2021                    |
| NAME OF PI    | ROVIDER OR SUPPLIER                                | STREET ADI  | DRESS, CITY, STA | TE, ZIP CODE  |                               |
| THE COM       | MONS   | 301 SOUT<br>ENID, OK  | H OAKWOOD I      | ROAD  |                               |
| (X4) ID       | SUMMARY ST   | ATEMENT OF DEFICIENCIES                                     | ID               | PROVIDER'S PLAN OF CORRECTIO  | N (X5)                        |
| PREFIX<br>TAG | (EACH DEFICIENC)                                   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE                   |
| LL610         | Continued From page                                | e 117   | LL610            |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               |  |   |                  |   |                               |
|               | On 06/25/21, an Imm                                |   |                  |   |                               |
|               | situation was determi<br>facility's failure to ens | ned to exist related to the                                 |                  |   |                               |
|               |  | mmediately after identifying                                |                  |   |                               |
|               | suspected and/or acti                              | ual abuse had occurred.                                     |                  |   |                               |
|               | A staff member allege                              | ed that LPN #3 had been                                     |                  |   |                               |
|               | refusing/withholding p                             | pain medications to resident                                |                  |   |                               |
|               | · ·  | as not reported timely to the                               |                  |   |                               |
|               | administrator for inves                            | stigation.  |                  |   |                               |
|               |  | being verbally abusive to                                   |                  |   |                               |
|               |  | 21 was not reported until                                   |                  |   |                               |
|               | υΖΙΖΟΙΖΙ, one day aπ                               | er the allegation occured.                                  |                  |   |                               |
|               | <u>-</u>   | ed an incident of resident #5                               |                  |   |                               |
|               |  | ed by staff witnessed and                                   |                  |   |                               |
|               |  | e facility failed to protect the thorough investigation and |                  |   |                               |
|               |  | measures to prevent further                                 |                  |   |                               |
|               | abuse.   |   |                  |   |                               |
|               | Staff witnessed verba                              | ıl abuse to Resident #6, by                                 |                  |   |                               |
|               |  | orted it to the charge nurse.                               |                  |   |                               |

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|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ′                 | CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|-----------------------|---|----------------------------|
|                          |   |   | A. BOILDING.          |   |                            |
|                          |   | NH2407  | B. WING               |   | C<br><b>07/01/2021</b>     |
| NAME OF D                |   | OTDEET AS   | DDEGG OITY OTA        | TE 7/D 00DE   |                            |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STA     |   |                            |
| THE COM                  | MONS  | 301 SOU<br>ENID, OK   | TH OAKWOOD F<br>73706 | ROAD  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE                |
| LL610                    | Continued From page   | : 118   | LL610                 |   |                            |
|                          | The charge nurse did the administrator time                                   | not report the allegation to ly.  |                       |   |                            |
|                          |   | ahoma State Department of otified and verified the uation.  |                       |   |                            |
|                          | At 11:28 a.m., the Adr<br>notified of the IJ.                                 | ninistrator (ADM) was   |                       |   |                            |
|                          |   | removal was provided by<br>6/25/21 at 9:55 p.m. It<br>ving:   |                       |   |                            |
|                          | staff on shift will be ed<br>immediately, and if no<br>inserviced by phone of | nterviewed 06/25/2021. All ducated on updated policy of currently working will be sall by midnight on ched) (amended to be 9 am |                       |   |                            |
|                          | date and time, and the<br>off the schedule until<br>The following texts wi    | •   |                       |   |                            |
|                          | deficiencies in Abuse required to complete i                                  | reporting. All staff are<br>n-service. Someone from<br>calling you before midnight  |                       |   |                            |
|                          | complete an in-service of nursing] or will be rescheduleBeginning             | e by midnight, call [director<br>emoved from the<br>IMMEDIATELY-reporting of  |                       |   |                            |
|                          | or called to [administrator]This is   | s will be need to be texted<br>ator][assistant<br>s any time- DAY or NIGHT!<br>kt, then CALLAll staff that                      |                       |   |                            |
|                          | have been identified a<br>will be given a 1 day s<br>-Staff member with ph    | ss not timely reporting abuse suspension. [Resident #5] sysical abuse allegation will ately. At every allegation of             |                       |   |                            |

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| STATEMENT OF D<br>AND PLAN OF COI  |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                      | CONSTRUCTION   | (X3) DATE SURVE<br>COMPLETED |                         |
|--|---|---|----------------------|--|------------------------------|-------------------------|
|  |   |   | D WING               |  | С                            |                         |
|  |   | NH2407  | B. WING              |  | 07/01/20                     | 021                     |
| NAME OF PROVID   | ER OR SUPPLIER  |   | RESS, CITY, STA      | ,  |                              |                         |
| THE COMMONS  | S   | ENID, OK  | I OAKWOOD F<br>73706 | ROAD   |                              |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE CO                        | (X5)<br>OMPLETE<br>DATE |
| abustafalle NO Assathor survivor que We exathat stafalear repolear mustatass occoord On cert practical (RN main interelate At 6 did abusta operation survivor que we exathat stafalear repolear mustatass occoord on cert practical (RN main interelate At 6 did abusta operation survivor and main interelate At 6 did abusta operation survivor and main info was survivor and mai | If that we take abuse gation has been reforms of abuse wist Administrator and rough investigation veys on all halls the ked. Handwritten sestioned should be have reviewed the imples of abuse and thave been update of members on the med that the witnes orted the incident of med that to proper st conduct medical tus assessment at the each shifter and the incident of | ent to all staff to remind se very seriouslyAn eported, this is a reminder II be tolerated Administrator, d DON have learned that a includes resident safe at the alleged abuser has estatements from those included in an investigation. It is different types and individual i | LL610                |  |                              |                         |

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|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE       | CONSTRUCTION   | (X3) DATE SURVEY |   |
|--------------------------|--|---|---------------------|--|------------------|---|
| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDING: _      |  | COMPLETED        |   |
|                          |  |   |                     |  | С                |   |
|                          |  | NH2407  | B. WING             |  | 07/01/2021       |   |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, STA    | TE, ZIP CODE   |                  |   |
| THE COM                  | MONO   | 301 SOUT  | H OAKWOOD F         | ROAD   |                  |   |
| THE COM                  | MIONS  | ENID, OK  | 73706               |  |                  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETI    | Ë |
| LL610                    | Continued From page  | e 120   | LL610               |  |                  |   |
|                          | that an amended plandue to ongoing abuse being reported timley conducting thorough  An acceptable plan of the administrator on (documented the follow)  "Plan of AMENDED Formula in the document of the follow)"   | f removal was provided by<br>06/29/21 at 7:20 p.m. It<br>wing:                        |                     |  |                  |   |
|                          | 2021 [By 8:00 p.m.] Misappropriation InveupdatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the ADON [assistant direction outside agency. Due 06/28/21 [staff name | Abuse, Neglect,<br>estigation POLICY was  |                     |  |                  |   |
|                          | the INCIDENT RESP<br>and includes the Adm<br>Administrator, DON, A<br>Center Resident serv<br>administrator or desig<br>Director any allegatio<br>scheduled monthly m<br>INCIDENT response<br>an outside source on<br>including screening, p                         | ADON, and HealthCare  |                     |  |                  |   |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 121 of 227

Oklahoma State Department of Health

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE Co    |  | , ,                               | E SURVEY<br>PLETED       |
|--------------------------|---|--|---------------------|--|-----------------------------------|--------------------------|
|                          |   |  |                     |  |                                   | С                        |
|                          |   | NH2407   | B. WING             |  | 07                                | //01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET A   | ODRESS, CITY, STATE | , ZIP CODE   |                                   |                          |
| THE COM                  | MONS  |  | TH OAKWOOD RO       | AD   |                                   |                          |
|                          | CUMMARY CT  | ENID, OF   |                     | DDOV/DEDIC DI ANI OF   | CORRECTION                        |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL610                    | Continued From page   | e 121  | LL610               |  |                                   |                          |
|                          | always protect our response team will m   | anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and s to ensure all thorough n completed."  |                     |  |                                   |                          |
|                          | were interviewed and information related to administrative staff w  | Ns, one RN and three CMAs able to state accurate abuse and neglect and five ere interviewed and were information related to  |                     |  |                                   |                          |
|                          | of 06/30/21 at 5:10 p.<br>plan of removal and t<br>had been implemente  | rdy deficiency was lifted as<br>m. when all elements of the<br>he amended plan of removal<br>ed. The deficient practice<br>f actual harm at a pattern.   |                     |  |                                   |                          |
|                          | ensure staff reported immediately after idea  | ermined the facility failed to<br>allegations of abuse<br>ntifying abuse/suspected<br>or four (#5, 6, 7 and #9) of   |                     |  |                                   |                          |
|                          | The facility identified facility.   | 95 residents resided in the  |                     |  |                                   |                          |
|                          | Findings:   |  |                     |  |                                   |                          |
|                          | "Reporting Requirem-<br>reported immediately<br>and to other officials i<br>law. Allegations that<br>reported within 2 hou<br>be thoroughly investion<br>further potential abus | ed 12/08/2020, documented, entsallegations shall be to the administrator, DON in accordance with State involve abusemust be rsThese allegations must gated and must prevent e while the investigation is in e action must be taken |                     |  |                                   |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 122 of 227

| Okiahoma          | a State Department of                     | Health                            |                  |                                 |        |                  |
|-------------------|---|-----------------------------------|------------------|---------------------------------|--------|------------------|
|                   | OF DEFICIENCIES                           | (X1) PROVIDER/SUPPLIER/CLIA       | (X2) MULTIPLE    | IPLE CONSTRUCTION (X3) DATE SUF |        |                  |
| AND PLAN C        | OF CORRECTION                             | IDENTIFICATION NUMBER:            | A. BUILDING: _   |                                 | COMPLI | ETED             |
|                   |   |                                   |                  |                                 |        |                  |
|                   |   | NH2407                            | B. WING          |                                 | 1      |                  |
|                   |   | NHZ407                            |                  |                                 | 07/0   | 1/2021           |
| NAME OF PF        | ROVIDER OR SUPPLIER                       | STREET AD                         | DRESS, CITY, STA | TE, ZIP CODE                    |        |                  |
|                   |   | 301 SOUT                          | H OAKWOOD F      | ROAD                            |        |                  |
| THE COM           | MONS                                      | ENID, OK                          |                  |                                 |        |                  |
| 240.15            | SLIMMARY ST.                              | ATEMENT OF DEFICIENCIES           |                  | PROVIDER'S PLAN OF CORRECTION   | ıı     | 0/5)             |
| (X4) ID<br>PREFIX |   | Y MUST BE PRECEDED BY FULL        | ID<br>PREFIX     | (EACH CORRECTIVE ACTION SHOULD  |        | (X5)<br>COMPLETE |
| TAG               | ,   | LSC IDENTIFYING INFORMATION)      | TAG              | CROSS-REFERENCED TO THE APPROPE |        | DATE             |
|                   |   |                                   |                  | DEFICIENCY)                     |        |                  |
| LL610             | Cantinued From page                       | - 400                             | LL610            |                                 |        |                  |
| LLUIU             | Continued From page                       |                                   | LLUIU            |                                 |        |                  |
|                   |   | e appropriate licensing           | 1                |                                 |        |                  |
|                   |   | t [sic] the policy of The         | 1                |                                 |        |                  |
|                   |   | resident will be free from        | 1                |                                 |        |                  |
|                   |   | acility staff will be in-serviced | 1                |                                 |        |                  |
|                   |   | nt, and at least annually         | 1                |                                 |        |                  |
|                   | thereafter, regarding                     |                                   | 1                |                                 |        |                  |
|                   | _   | report any suspicion of           | 1                |                                 |        |                  |
|                   |   | streatment to your immediate      | 1                |                                 |        |                  |
|                   |   | ervisor WILL CALL the CELL        | 1                |                                 |        |                  |
|                   |   | STRATOR [admin], then the         | 1                |                                 |        |                  |
|                   |   | substantiated cases must          | 1                |                                 |        |                  |
|                   |   | espective agencies such as        | 1                |                                 |        |                  |
|                   |   | nforcement, physician;            | 1                |                                 |        |                  |
|                   |   | ent responsible party. The        | 1                |                                 |        |                  |
|                   | _   | l be routinely and openly         | 1                |                                 |        |                  |
|                   |   | tionProcedure1stCare              | 1                |                                 |        |                  |
|                   | · ·                                       | CT the resident-DON,              | 1                |                                 |        |                  |
|                   |   | ervisor should do a medical       | 1                |                                 |        |                  |
|                   |   | telydocumenting any injury        | 1                |                                 |        |                  |
|                   | in detailTake a state                     |                                   | 1                |                                 |        |                  |
|                   |   | e the perpetrator3rd              | 1                |                                 |        |                  |
|                   |   | the Administrator, then DON       | 1                |                                 |        |                  |
|                   | "   |                                   |                  |                                 |        |                  |
|                   |   |                                   |                  |                                 |        |                  |
|                   |   | liagnoses which included          |                  |                                 |        |                  |
|                   | chronic pain and oste                     | oarthritis.                       |                  |                                 |        |                  |
|                   | A ===:d===                                | at data d 04/44/04                |                  |                                 |        |                  |
|                   | A resident assessmer                      |                                   |                  |                                 |        |                  |
|                   | documented the resid moderately impaired. | •                                 |                  |                                 |        |                  |
|                   |   |                                   |                  |                                 |        |                  |
|                   | Δ care plan effective                     | date 01/07/21, documented,        |                  |                                 |        |                  |
|                   | •   | for pain r/t [related to]         |                  |                                 |        |                  |
|                   | muscle spasms and c                       |                                   |                  |                                 |        |                  |
|                   | syndromeResident                          |                                   |                  |                                 |        |                  |
|                   | •   | imely mannerAdminister            |                  |                                 |        |                  |
|                   | medications as presci                     |                                   |                  |                                 |        |                  |
|                   |   | nibed                             |                  |                                 |        |                  |
|                   | Physician's orders, da                    | ated 06/08/21, documented,        |                  |                                 |        |                  |
|                   |   | [milligrams]-acetaminophen        |                  |                                 |        |                  |

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|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE       | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|---|-------------------------------|
| AND PLAN                 | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDING: _      | BUILDING:   |                               |
|                          |   | NH2407   | B. WING             |   | C<br>07/01/2021               |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | RESS, CITY, STA     | TE ZIR CODE   | 1 07/01/2021                  |
| TVAINE OF T              | NOVIDER OR GOLF EIER  |  | H OAKWOOD F         |   |                               |
| THE COM                  | MONS  | ENID, OK   |                     | NOAD  |                               |
| ()(1) ID                 | SLIMMARY ST.  | ATEMENT OF DEFICIENCIES  |                     | PROVIDER'S PLAN OF CORRECTION   | ON (VE)                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETE                 |
| LL610                    | Continued From page   | e 123  | LL610               |   |                               |
|                          |   | ) give 1 tablet by oral route<br>ded FOR CHRONIC PAIN  |                     |   |                               |
|                          | Tylenol 325 mg capsuroute every 6 hours a   | ule give 2 tablets by oral s needed for pain   |                     |   |                               |
|                          | Ultram 50 mg tablet g<br>route every 6 hours a  | ive 1 tablet (50 mg) by oral s needed for pain"  |                     |   |                               |
|                          | 12:35 a.m., document on multiple occasions thing in the morning a [Resident #9] get up to ask for a pain pill. He Norco and rate his parabutt pain. As protoco request to the charge go to the resident to e report back to me, the | A #3, dated 06/26/21 at ted, "Generally every day, s, typically beginning first after the CNA has helped out of bed for the day, he will ewill specifically ask for a ain at an 8 out of 10 for leg or I, as the CMA, I report the nurse, the charge nurse will evaluate the resident and example CMA, with guidance to d and instruct me with the |                     |   |                               |
|                          | location of th [sic] pair [LPN #3], will deny th name], pain meds statedoesn't need a pain pamoke a cigarette, he he can go outside to a pain pill because he hon these occurances  | n. On many occurrences, e resident, [Resident's ting 'He just got up, he ill' or 'He's going outside to 's not hurting bad enough if smoke' or 'He can't have a nasn't eaten anything yet.' , [Resident] won't receive times 10 a.m or as late a 2 he MAR [medication  |                     |   |                               |
|                          | Abuse/Mistreatment  | dent #9]Allegations of<br>.Description of<br>ed Nurse not approving PRN<br>dent asked for them.  |                     |   |                               |

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|               | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE C     |   |                                    | SURVEY           |
|---------------|--|--|---------------------|---|------------------------------------|------------------|
| AND FLAIN     | OF CORRECTION  | IDENTIFICATION NOWIBER.  | A. BUILDING:        | COMPLE  |                                    | -LETED           |
|               |  |  |                     |   |                                    | С                |
|               |  | NH2407   | B. WING             |   | 07                                 | /01/2021         |
| NAME OF P     | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATE | , ZIP CODE  |                                    |                  |
|               |  | 301 SOL  | ITH OAKWOOD RO      | )AD   |                                    |                  |
| THE COM       | MONS   | ENID, O  | K 73706             |   |                                    |                  |
| (X4) ID       | SUMMARY ST   | ATEMENT OF DEFICIENCIES  | ID                  | PROVIDER'S PLAN OF  | CORRECTION                         | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG       | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | TION SHOULD BE<br>ITHE APPROPRIATE | COMPLETE<br>DATE |
| LL610         | Continued From page  | e 124  | LL610               |   |                                    |                  |
|               | called"  |  |                     |   |                                    |                  |
|               | 12:23 [did not docum<br>documented, "Somet<br>pills when it is not tim<br>is scheduled [every] &<br>offered Tylenol if Nord  | imes resident asks for pain<br>e as he had it earlier. Med<br>ß [hours] prn. Resident is<br>co can't be given yet"   |                     |   |                                    |                  |
|               | _  | enducted with five residents.<br>to the residents were not<br>ain medications.   |                     |   |                                    |                  |
|               |  | ed the allegation was completed on 06/27/21 at   |                     |   |                                    |                  |
|               | The employee continuinvestigaion of the all  | ued to work during the eged negelct.   |                     |   |                                    |                  |
|               | The facility did not co investigation and inte include the alleged vi medications being with   | rview residents and staff to ctim regarding pain   |                     |   |                                    |                  |
|               | assistant administrate conclusion of the investadministrator stated is spreadsheet of which versus the Norco. She had administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it withheld the medication. | p.m., the administrator and or were asked about the estigation. The assistant she had made an excel nurse had given Tylenol ne stated the accused nurse medications as much as the as asked if there was times the resident had She stated she didn't think the had requested it. She was a documentation of when the and the CMA stated LPN #3 on, how did they come to the tion was unsubstantiated. |                     |   |                                    |                  |

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|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | CONSTRUCTION   | (X3) DATE S |                          |
|--------------------------|---|--|---------------------|--|-------------|--------------------------|
| ANDILAN                  | or connection   | IDENTIFICATION NOMBER.   | A. BUILDING: _      | A. BUILDING:   |             | LILD                     |
|                          |   | NH2407   | B. WING             |  | 07/0        | ;<br>1/2021              |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | RESS, CITY, STA     | TE, ZIP CODE   | 1 00        |                          |
| TUE 00M                  | MONO  | 301 SOUTH  | I OAKWOOD I         | ROAD   |             |                          |
| THE COM                  | MONS  | ENID, OK   | 73706               |  |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE          | (X5)<br>COMPLETE<br>DATE |
| LL610                    | him about it. She star nurse's biggest cheer  At 1:19 p.m., the ADM. There were no questirelated to staff withhous tated the executive of surveys and thought the members respect you make decisions regard that.  On 06/29/21 at 6:35 prif he was in pain. He right side, leg and known rate it at an 8 out of 1 a 9 in the mornings. The did not get his Northe stated, "If I don't gwas asked if his Norce stated it was and there disclose who the empired medication.  At 7:02 p.m., CMA #3 allegations made regard Norco. She stated, "If the time." She stated because when he ask protocol I have to follow would give the same in her statement. She take their pain as they #3 would have her ad instead of the Norco.  2. Resident #7 was as | to the resident and asked ted the resident is this leader.  If provided resident surveys one asked to the residents Iding pain medications. She director had made the that the question "Do staff in requests and allow you to ding your care" covered  In the resident was asked stated he had pain in his ee. She stated he would one of the them of the them of the paint in his ee. She stated he would he was asked how he felt if the owner withheld. He is them, I get mad." He owner withheld. He is the them of the paint in the pai | LL610               |  |             |                          |
|                          | diagnoses which inclu<br>anxiety disorder.  | uaea convuisions and   |                     |  |             |                          |

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|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | ` ′                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:                                      |                                   |                          |
|--------------------------|--|---|---------------------|---|-----------------------------------|--------------------------|
|                          |  |   | A. BOILBING.        |   |                                   | С                        |
|                          |  | NH2407  | B. WING             |   | 07                                | 7/01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, STATE | , ZIP CODE  |                                   |                          |
| TUE 001                  |  | 301 SOU   | TH OAKWOOD RO       | AD  |                                   |                          |
| THE COM                  | MONS   | ENID, OK  | 73706               |   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO DEFICIENCED | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL610                    | Continued From page  | e 126   | LL610               |   |                                   |                          |
|                          |  | assessment, dated 02/18/21,<br>dent's cognition was severely  |                     |   |                                   |                          |
|                          | documented, "Incid Abuse/Mistreatment IncidentAdministrat allegation of verbal al from a staff member is not on the schedule not be working until the investigated. Investigated and final reports, of the investigation implemented to prevent attached for investigation seriedent. She was sure ways to recognize but allegation of abu | or was notified today of an buse occurring on 02/22/21 against a nurse. The nurse e until Thursday. She will he allegation has been gation is in progressFor 5 please include a summary and corrective measures ent recurrenceSee ation: Nurse yelled at uspended and counseled on rnout. Also gave her |                     |   |                                   |                          |
|                          | within two hours to th   | eport the allegation of abuse<br>e appropriate agencies such<br>te Department of Health   |                     |   |                                   |                          |
|                          | documented, "The da<br>spent a majority of the<br>hallway outside of [ar<br>approximately 2 p.m.<br>himself in his wheelch<br>station area and park<br>outside of the wound<br>Immediately the char-   | y CMA #3, dated 02/23/21, ay of 2-22-21, [resident #7] e day sitting in the North Hall nother resident]s room. At [resident #7] wheeled hair up closer to the nurse's ed himself in his wheelchair care nurse's office. ge nurse, [LPN #3], stood up at #7] "get the hell out of                        |                     |   |                                   |                          |

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|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                      | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|----------------------|---|-------------------------------|
| ANDILAN                  | or connection  | IDENTIFICATION NOMBER.  | A. BUILDING: _       |   | COMI LETED                    |
|                          |  | NH2407  | B. WING              |   | C<br>07/01/2021               |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA      | TE, ZIP CODE  |                               |
| THE COM                  | MONS   | 301 SOUTH<br>ENID, OK   | I OAKWOOD I<br>73706 | ROAD  |                               |
| ()(1) ID                 | SLIMMARY ST  | ATEMENT OF DEFICIENCIES   |                      | PROVIDER'S PLAN OF CORRECTION   | N (VE)                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE                   |
| LL610                    | Continued From page  | e 127   | LL610                |   |                               |
|                          | here." [Resident #7] yelled at [LPN #3]. It at her, his speech is to to health conditions. again "get the hell ou talk to me that way." [resident #7] wheeled nurse's station area be his roomDuring this sitting in a chair besidentire event"  A written statement be documented, "On Mo #4] came into work I witting at nurses static came strolling up to the nurses station [LPN # around and go back heald I dont care Im no and he said he wanter screamed at him and your [sic] not sitting u deal with your Ass. so | g to sit up here while I'm did raise his hands and do not know what he yelled often hard to make out due [LPN #3] then yelled at him to fhere, you're not going to After this occurrence, I himself away from the tack down the hall towards occurrence, [CMA #4] was de me and witnessed the cocurrence of the light of the |                      |   |                               |
|                          | documented, "The oting getting something what [resident #7]. And [Resident #7] started #3] got louder and tol  | y CNA #3, dated 02/24/21,<br>her day I was in the office<br>en I heard [LPN #3] yelling<br>telling him to go to his room.<br>yelling back at her and [LPN<br>d him she wasn't going to<br>r room. [LPN #3] then said<br>like this"  |                      |   |                               |
|                          |  | ary, undated, documented,<br>ent happenAround 2pm<br>ndWhen was facility  |                      |   |                               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1  | CONSTRUCTION         | (X3) DATE SURVEY<br>COMPLETED   |               |                        |
|---|---|--|----------------------|---|---------------|------------------------|
| ANDILAN   | or connection   | BENTI TOATION NOMBER.  | A. BUILDING: _       |   |               |                        |
|   |   | NH2407   | B. WING              |   | C<br>07/01/20 | 21                     |
| NAME OF F   | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA      | TE, ZIP CODE  |               |                        |
| THE COM   | IMONS   | 301 SOUTH<br>ENID, OK  | I OAKWOOD I<br>73706 | ROAD  |               |                        |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE CO         | (X5)<br>MPLETE<br>DATE |
| LL610   | supervisory/managen about the incidentO  On 06/23/21 at 2:24 p who the staff could re She stated, "Any auth the staff had witnesse timely. She stated, "N staff who witnessed the about reporting timely writing."  On 06/24/21 at 1:09 p verbal abuse happend p.m. She stated "Yes continued to work after was asked if LPN #3 residents, how were the stated," They couldn't about it." She was as report the abuse imm protected. She stated. The staff members who immediately report worked with the victim approximately four hor staff was asked if LPN #3 are sidents, how were the staff members who immediately report worked with the victim approximately four hor staff was and diagnoses which included the residually decision making. An initial incident reports | nent staff first contacted in Feb 23rd"  o.m., the admin was asked port suspected abuse to ority." She was asked when ad the abuse, did they report to." She was asked if the ne abuse were inserviced or She stated, "Nothing in ority." She was asked if the ne abuse were inserviced or She stated, "Nothing in ority." She was asked if LPN #3 for She stated, "Yes." She continued to work with the resident protected. She be, because we didn't know sked, since the staff failed to rediately, were the residents or owitnessed the abuse did to it. As a result, LPN #3 in and other residents for ours and 48 minutes.  Idmitted to the facility with added dementia.  Sesessment, dated 05/02/21, dent's cognitive skills for was severely impaired.  Out form, dated 06/07/21, dentInvolved[Resident allegations of Description of | LL610                |   |               |                        |

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|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                      | CONSTRUCTION  | (X3) DATE S |                          |
|--------------------------|--|---|----------------------|---|-------------|--------------------------|
| ANDILAN                  | or dorate of the transfer of t | IDENTIFICATION NOMBER.  | A. BUILDING: _       | A. BUILDING:  |             |                          |
|                          |  | NH2407  | B. WING              |   | 07/0        | )<br>1/2021              |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA      | TE, ZIP CODE  |             |                          |
| THE COM                  | MONS   | 301 SOUTH<br>ENID, OK   | I OAKWOOD I<br>73706 | ROAD  |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE          | (X5)<br>COMPLETE<br>DATE |
| LL610                    | A written statement fro 06/07/21, documented #2] asked me if I coul yes just give me a semiddle of taking care I walked into [resident ahold [sic] of his Righ on him while she was bare skin I yelled at way [and] she was lik dropped him back on his arm to get him up would take care of hir breakfast [and] told the just happened. When #2] she told her to state [resident #5]. When I [10:00 a.m.] I asked if [and] I told [DON] who me she was not awar asked me to write out.  A written statement frodocumented, "[CMA # yelled at [CNA #2] be me to help get him [resoom where she was at her states she saw at his left leg so I told finish him, I went to [continue to the said I was not anyone was room"  | om CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had t arm yanking [and] pulling slapping at his left leg,-on ther to stop doing him that e what [and] just kind of the bed, she went to pull on I told her to just leave that I m. I brought him out for the Charge Nursewhat had in [LPN #2] talked to [CNA the yaway from direct care of the seen [sic] D.O.Naround for [LPN #2] had talk to her that had happened She told the but now she is [and] to a statement"  The cause she came out to ask the sident #5] up I went into the the and he was mad and hitting ther grab his arm and swat her to leave and I would condition in the stold by nurse to stay out of the mary, undated, documented, | LL610                |   |             |                          |
|                          |  | ent happen06/07/21, [7:30   |                      |   |             |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 130 of 227

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| AND DUAN OF CORRECTION DENTIFICATION NUMBER  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|-------------------------------|--|
| A. BUILDING:   |                               |  |
|  | C<br><b>/01/2021</b>          |  |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |  |
| THE COMMONS  301 SOUTH OAKWOOD ROAD  ENID, OK 73706  |                               |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY)   | (X5)<br>COMPLETE<br>DATE      |  |
| LL610  Continued From page 130  supervisory/management staff first contacted about the incident[10:00 a.m.]"  On 06/24/21 at 12:48 p.m., the DON acknowledged staff did not notify DON or ADM of the incident in a timely manner.  LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours.  4. Resident #6 had diagnoses which included Huntington's disease.  A resident assessment, dated 02/15/21, documented the resident's cognition was intact.  A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back"  An initial OSDH incident report, dated 03/21/21, documented, "Allegations of Abuse MistreatmentDescription of IncidentAdministrator was notified by Activity director that activity aider eported to her in a statement, that she overheard a nurse say "Jesus Fr*** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete" A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.  On 06/24/21 at 1:35 p.m., the DON was asked if was reported timely. She stated she was not notified until the next day.  On 06/25/21 at 3:09 a.m., the activity aide was |                               |  |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | OF DEFICIENCIES DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|--|---|-------------------------------|--------------------------|
|                          |   |  | A. BOILDING.                             |   | c                             |                          |
|                          |   | NH2407   | B. WING                                  |   | 1                             | /2021                    |
| NAME OF PI               | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA                          | TE, ZIP CODE  |                               |                          |
| THE COM                  | MONS  | 301 SOUTH<br>ENID, OK 7  | I OAKWOOD F<br>73706                     | ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                          | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL610                    | Continued From page   | e 131  | LL610                                    |   |                               |                          |
|                          | stated she reported it  | eported the incident to. She to her supervisor that day or was going to call the                         |  |   |                               |                          |
| LL815                    | 310:675-9-1.1(a) NUI<br>CARE SERVICES   | RSING AND PERSONAL   | LL815                                    |   |                               |                          |
|                          | The facility shall ensurespected in the provi   | ire that resident rights are ision of care.  |  |   |                               |                          |
|                          | facility's failure to enshad been conducted actions were taken for A staff member allege refusing/withholding p. The allegation was administrator and a throot conducted. The e | ediate Jeopardy (IJ) ned to exist related to the ure a thorough investigation and appropriate corrective |  |   |                               |                          |
|                          |   | being verbally abusive to<br>21 was not reported until   |  |   |                               |                          |

Oklahoma State Department of Health

STATE FORM 6899 If continuation sheet 132 of 227 C7JI11

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     |  | (X3) DATE SURVEY<br>COMPLETED     |                          |
|--|---|---|---------------------|--|-----------------------------------|--------------------------|
|  |   | NH2407  | B. WING             |  | 07                                | C<br>7/ <b>01/2021</b>   |
| NAME OF F  | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | , ZIP CODE   | ,                                 |                          |
| THE COM  | IMONE   |   | ITH OAKWOOD RO      |  |                                   |                          |
| THE COM  | IMONS   | ENID, O   | K 73706             |  |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815  | 02/23/21, one day aff. The residents were in member was allowed. The facility document being physically abust reported by staff. The resident, complete a implement corrected abuse.  Resident #8 made are on 06/28/21 and the continue to work over allegation was made. Staff witnessed verbaran employee and reported to the action to the action of the investigation of the investigation was made. At 11:04 a.m., the Ok Health (OSDH) was residented of the IJ site At 11:28 a.m., the Adnotified of the IJ.  An acceptable plan of the administrator on additional manner will be staff on shift will be estaff on shift will be estaff on shift will be a site of the staff on shift will be estaff on shift will be | ter the allegation occurred. Into protected as the staff It to work.  Ited an incident of resident #5 Ited by staff witnessed and Ite facility failed to protect the Iteration and investigation and Iteration of rape by staff Iteration of | LL815               |  |                                   |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 133 of 227

Oklahoma State Department of Health

| Oklanom           | a State Department of    | i icailii                       |                  |                                 |                               | _        |
|-------------------|--------------------------|---------------------------------|------------------|---------------------------------|-------------------------------|----------|
|                   | OF DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA     | (X2) MULTIPLE    | CONSTRUCTION                    | (X3) DATE SURVEY<br>COMPLETED |          |
| AND PLAN (        | OF CORRECTION            | IDENTIFICATION NUMBER:          | A. BUILDING: _   | A. BUILDING:                    |                               |          |
|                   |                          |                                 |                  |                                 | С                             |          |
|                   |                          | NH2407                          | B. WING          |                                 |                               |          |
|                   |                          | NH2407                          |                  | <del>-</del>                    | 07/01/2021                    | $\dashv$ |
| NAME OF P         | ROVIDER OR SUPPLIER      | STREET ADI                      | DRESS, CITY, STA | TE, ZIP CODE                    |                               |          |
|                   |                          | 301 SOUT                        | H OAKWOOD I      | ROAD                            |                               |          |
| THE COM           | MONS                     | ENID, OK                        | 73706            |                                 |                               |          |
| 040.15            | STIMMADV ST              | ATEMENT OF DEFICIENCIES         |                  | PROVIDER'S PLAN OF CORRECTION   | 1 0/5)                        | —        |
| (X4) ID<br>PREFIX |                          | Y MUST BE PRECEDED BY FULL      | ID<br>PREFIX     | (EACH CORRECTIVE ACTION SHOULD  | ( - /                         | :        |
| TAG               |                          | SC IDENTIFYING INFORMATION)     | TAG              | CROSS-REFERENCED TO THE APPROPE | IATE DATE                     |          |
|                   |                          |                                 |                  | DEFICIENCY)                     |                               |          |
| LL815             | Continued From page      | 133                             | LL815            |                                 |                               |          |
| 22010             | Continued From page      | , 100                           | 220.0            |                                 |                               |          |
|                   | on 06/26/2021)           |                                 |                  |                                 |                               |          |
|                   |                          | acted, we will document         |                  |                                 |                               |          |
|                   |                          | e staff member will be taken    |                  |                                 |                               |          |
|                   | off the schedule until   | completed**                     |                  |                                 |                               |          |
|                   | The following texts wi   |                                 |                  |                                 |                               |          |
|                   | ,                        | ors have identified serious     |                  |                                 |                               |          |
|                   |                          | reporting. All staff are        |                  |                                 |                               |          |
|                   | required to complete i   | in-service. Someone from        |                  |                                 |                               |          |
|                   |                          | calling you before midnight     |                  |                                 |                               |          |
|                   | tonightIf you have b     |                                 |                  |                                 |                               |          |
|                   | complete an in-service   | e by midnight, call [director   |                  |                                 |                               |          |
|                   | of nursing] or will be r |                                 |                  |                                 |                               |          |
|                   | , , ,                    | IMMEDIATELY-reporting of        |                  |                                 |                               |          |
|                   | _                        | s will be need to be texted     |                  |                                 |                               |          |
|                   | or called to [administr  |                                 |                  |                                 |                               |          |
|                   |                          | s any time- DAY or NIGHT!       |                  |                                 |                               |          |
|                   | T                        | xt, then CALLAll staff that     |                  |                                 |                               |          |
|                   |                          | as not timely reporting abuse   |                  |                                 |                               |          |
|                   |                          | suspension. [Resident #5]       |                  |                                 |                               |          |
|                   |                          | nysical abuse allegation will   |                  |                                 |                               |          |
|                   |                          | iately. At every allegation of  |                  |                                 |                               |          |
|                   |                          | ent to all staff to remind      |                  |                                 |                               |          |
|                   |                          | se very seriouslyAn             |                  |                                 |                               |          |
|                   | _                        | eported, this is a reminder     |                  |                                 |                               |          |
|                   |                          | ill be tolerated Administrator, |                  |                                 |                               |          |
|                   |                          | d DON have learned that a       |                  |                                 |                               |          |
|                   |                          | n includes resident safe        |                  |                                 |                               |          |
|                   | _                        | at the alleged abuser has       |                  |                                 |                               |          |
|                   |                          | statements from those           |                  |                                 |                               |          |
|                   | •                        | included in an investigation.   |                  |                                 |                               |          |
|                   | We have reviewed the     |                                 |                  |                                 |                               |          |
|                   |                          | nd will follow our policies     |                  |                                 |                               |          |
|                   | ·                        | ed. We will in-service all      |                  |                                 |                               |          |
|                   |                          | attached education. We          |                  |                                 |                               |          |
|                   |                          | ess is the person that has      |                  |                                 |                               |          |
|                   |                          | during the investigation. We    |                  |                                 |                               |          |
|                   |                          | ly assess the resident we       |                  |                                 |                               |          |
|                   |                          | l, psychosocial, and mental     |                  |                                 |                               |          |
|                   | status assessment at     | the time, and an                |                  |                                 |                               |          |

Oklahoma State Department of Health

assessment each shift for 3 days for 9

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|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  |                     | CONSTRUCTION   | , ,                             | E SURVEY<br>PLETED       |
|--------------------------|--|--|---------------------|--|---------------------------------|--------------------------|
|                          |  |  | A. BOILDING         | A. BUILDING:   |                                 | 0                        |
|                          |  | NH2407   | B. WING             |  | 07                              | C<br><b>7/01/2021</b>    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATI | E, ZIP CODE  | •                               |                          |
| THE COM                  | MONO   |  | TH OAKWOOD R        |  |                                 |                          |
| THE COM                  | MONS   | ENID, OF   | 73706               |  |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815                    | Continued From page  | e 134  | LL815               |  |                                 |                          |
|                          | occurrences"   |  |                     |  |                                 |                          |
|                          | certified medication a practical nurses (LPN (RN), seven houseke maintenance staff fro interviewed and able related to abuse.  At 6:57 a.m., the ADN did to further educate abuse. She stated shoperations manual ar her administrator foru if she shared that info administrative staff. Sinformation themselve was anything specific | m across all shifts, were to state accurate information  If was asked what the facility the administrative staff on the looked through the state and reached out to some of the sonline. She was asked to be stated they looked up the stated they looked up the stated they looked if there |                     |  |                                 |                          |
|                          | specific."   | one outloo, 110, 110 a.m.g   |                     |  |                                 |                          |
|                          | staff contnued to worl<br>allegation. A staff me<br>had been refusing/wit  | staff on 06/28/21 and the c over six hours after the ember alleged that LPN #3 chholding pain medications llegation was not reported rator and a thorough  |                     |  |                                 |                          |
|                          | that an amended plar<br>due to ongoing abuse   | inistrator was made aware<br>n of removal was needed<br>and neglect allegations<br>idents and conducting<br>ns.  |                     |  |                                 |                          |
|                          |  | f removal was provided by<br>06/29/21 at 7:20 p.m. It<br>wing:   |                     |  |                                 |                          |

Oklahoma State Department of Health

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Oklahoma State Department of Health

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | CONSTRUCTION   | (X3) DATE S |                          |
|--------------------------|---|--|---------------------|--|-------------|--------------------------|
| AND PLAN                 | OF CORRECTION   | IDENTIFICATION NUMBER.   | A. BUILDING: _      | A. BUILDING:   |             | EIED                     |
|                          |   |  | B. WING             |  |             |                          |
|                          |   | NH2407   | B. WING             |  | 07/0        | 1/2021                   |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | DRESS, CITY, STA    | •  |             |                          |
| THE COM                  | MONS  |  | H OAKWOOD I         | ROAD   |             |                          |
|                          |   | ENID, OK   |                     |  |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE          | (X5)<br>COMPLETE<br>DATE |
| LL815                    | Continued From page   | e 135  | LL815               |  |             |                          |
|                          | 2021 [By 8:00 p.m.] Misappropriation Inveue updatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the ADON [assistant direction outside agency. Due 06/28/21 [staff name   | completed by June 30th,<br>Abuse, Neglect,<br>estigation POLICY was  |                     |  |             |                          |
|                          | the INCIDENT RESP and includes the Adm Administrator, DON, A Center Resident serv administrator or design Director any allegation scheduled monthly manded in the Incident of | ADON, and HealthCare ices Director. The gnee will report to Board of n of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ng, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and is to ensure all thorough n completed." |                     |  |             |                          |
|                          | were interviewed and information related to   | Ns, one RN and three CMAs able to state accurate abuse and neglect and five ere interviewed and were   |                     |  |             |                          |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | , ,  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--|--|-------------------------------|--|
|   |   |  | A. BOILDING.                             |  | C                             |  |
|   |   | NH2407   | B. WING                                  |  | 07/01/2021                    |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA                          | TE, ZIP CODE   |                               |  |
| THE COM   | MONS  |  | OAKWOOD F                                | ROAD   |                               |  |
|   |   | ENID, OK   | 73706                                    |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE                   |  |
| LL815   | Continued From page   | : 136  | LL815                                    |  |                               |  |
|   | able to state accurate abuse and neglect.   | information related to   |  |  |                               |  |
|   | of 06/30/21 at 5:10 p.<br>plan of removal and the had been implemented  | rdy deficiency was lifted as<br>m. when all elements of the<br>ne amended plan of removal<br>ed. The deficient practice<br>actual harm at a pattern.   |  |  |                               |  |
|   | Based on record reviews, it was dete  | ew, resident and staff<br>ermined the facility failed to:  |  |  |                               |  |
|   | ~ ensure a thorough completed and   | investigation had been   |  |  |                               |  |
|   | abuse had been ideni  | iate corrective actions when<br>tified for six (#1, 5, 6, 7, 8<br>d residents reviewed for   |  |  |                               |  |
|   | The facility identified stacility.  | 95 residents resided in the  |  |  |                               |  |
|   | Findings:   |  |  |  |                               |  |
|   | "Reporting Requiremereported immediately and to other officials i law. Allegations that reported within 2 hour be thoroughly investig further potential abuse progressappropriate including report to the boardPreventionIt Commons that each rabuse, neglectAll fa | ed 12/08/2020, documented, entsallegations shall be to the administrator, DON n accordance with State involve abusemust be rsThese allegations must gated and must prevent e while the investigation is in a action must be taken appropriate licensing [sic] the policy of The resident will be free from incility staff will be in-serviced t, and at least annually |  |  |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED  |    |                          |  |
|---|--|--|---------------------|--|----|--------------------------|--|
|   |  |  |                     |  | c  | :                        |  |
|   |  | NH2407   | B. WING             |  | 1  | 07/01/2021               |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD   | DRESS, CITY, STA    | TE, ZIP CODE   |    |                          |  |
| THE COMMONS 301 SOUT  |  |  | H OAKWOOD I         | ROAD   |    |                          |  |
|   |  | ENID, OK   | 73706               |  |    |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5)<br>COMPLETE<br>DATE |  |
| LL815   | Continued From page  | e 137  | LL815               |  |    |                          |  |
|   | abuseImmediately rabuse, neglect or mis supervisorThe super phone of the ADMINIST DONSuspected or also be reported to restate agencies, law ending families, and/or resides subject of abuse shall discussedInvestigate for, treat and PROTE ADON, or house super assessment immediatin detailTake a state resident2ndIsolater   | report any suspicion of treatment to your immediate ervisor WILL CALL the CELL STRATOR [admin], then the substantiated cases must spective agencies such as inforcement, physician; ent responsible party. The I be routinely and openly tionProcedure1stCare CT the resident-DON, ervisor should do a medical telydocumenting any injury ement from the |                     |  |    |                          |  |
|   | chronic pain and oste  |  |                     |  |    |                          |  |
|   | A resident assessmer documented the resid moderately impaired.   |  |                     |  |    |                          |  |
|   | A care plan, effective date 01/07/21, documented, "Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndromeResident will have pain treated/relieved in a timely mannerAdminister medications as prescribed"  Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN  Tylenol 325 mg capsule give 2 tablets by oral |  |                     |  |    |                          |  |
|   |  |  |                     |  |    |                          |  |
|   | route every 6 hours a  |  |                     |  |    |                          |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  |                     | (X3) DATE SURVEY<br>COMPLETED   |                 |          |
|---|---|---|---------------------|---|-----------------|----------|
| AND FLAN  | OF CORRECTION   | IDENTIFICATION NUMBER.  | A. BUILDING:        |   | COMPLETED       |          |
|   |   | NH2407  | B. WING             |   | C<br>07/01/2021 |          |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                 |          |
| THE COM   | MONE  | 301 SOUTH   | OAKWOOD F           | ROAD  |                 |          |
| THE COM   | WON5  | ENID, OK  | 73706               |   |                 |          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE     | <b>E</b> |
| LL815   | route every 6 hours a  A statement from CM. 12:35 a.m., document on multiple occasions thing in the morning a [Resident #9] get up of ask for a pain pill. He Norco and rate his pain butt pain. As protoco request to the charge go to the resident to ereport back to me, the administer a pain med level of the pain that volocation of th [sic] pain [LPN #3], will deny the name], pain meds statedoesn't need a pain posmoke a cigarette, he he can go outside to spain pill because he hon these occurrences pain meds until some p.m. as reflected on the administration record.  An OSDH incident for documented, "[Resing Abuse/Mistreatment Incident Staff reported pain meds when resident is cognitive called" | sive 1 tablet (50 mg) by oral s needed for pain"  A #3, dated 06/26/21 at ted, "Generally every day, so typically beginning first after the CNA has helped but of bed for the day, he will evill specifically ask for a sin at an 8 out of 10 for leg or II, as the CMA, I report the nurse, the charge nurse will evaluate the resident and the evaluate the | LL815               |   |                 |          |
|   | -   | ent a.m. or p.m.],<br>imes resident asks for pain<br>e as he had it earlier. Med  |                     |   |                 |          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 139 of 227

Oklahoma State Department of Health

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | ` '                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                 |  |
|--------------------------|---|---|---------------------|---|-----------------|--|
|                          |   |   |                     |   | С               |  |
|                          |   | NH2407  | B. WING             |   | 07/01/2021      |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE |   |                 |  |
| THE COM                  | THE COMMONS   |   | TH OAKWOOD RO       | OAD   |                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE COMPLETE |  |
| LL815                    | is scheduled [every] & offered Tylenol if Nord Safe surveys were con The questions asked related to receiving particles of the facility document unsubstantiated and of 5:30 p.m.  The employee continuinvestigation of the all The facility did not coninvestigation and interinclude the alleged via medications being with On 06/28/21 at 12:40 assistant administrator stated as spreadsheet of which versus the Norco. She had administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it a withheld the medication conclusion the allegated She stated she went thim about it. She starnurse's biggest cheer | Inducted with five residents. To the residents were not ain medications.  Inducted with five residents. To the residents were not ain medications.  Inducted with five residents. To the residents were not ain medications.  Inducted with five residents. The allegation was completed on 06/27/21 at the leged neglect.  Inducted with five residents. The leged neglect were asked and staff to other regarding pain withheld.  In p.m., the administrator and or were asked about the estigation. The assistant whe had made an excel nurse had given Tylenol are stated the accused nurse medications as much as the as asked if there was times the resident had She stated she didn't think as had requested it. She was documentation of when the leand the CMA stated LPN #3 on, how did they come to the tion was unsubstantiated. The leader. | LL815               | DEFICIENCI  |                 |  |
|                          |   | I provided resident surveys.  ons asked to the residents  |                     |   |                 |  |

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STATE FORM 6899 C7JI11 If continuation sheet 140 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  |                     | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|---|--|---|---------------------|--|-------|--------------------------|
| ANDILAN   | or doring of the state of the s | IDENTIFICATION NOMBER.  | A. BUILDING: _      |  |       |                          |
|   |  | NH2407  | B. WING             |  | 07/0  | ;<br>1/2021              |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, STA    | ATE, ZIP CODE  |       |                          |
| THE COM   | MONS   | 301 SOUT<br>ENID, OK  | H OAKWOOD I         | ROAD   |       |                          |
| 0(1) 15   | STIMMADA ST  | ATEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF CORRECT   | ION   | 0(5)                     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| LL815   | Continued From page  | e 140   | LL815               |  |       |                          |
|   | stated the executive of<br>surveys and thought the<br>members respect you  | lding pain medications. She<br>director had made the<br>that the question "Do staff<br>ir requests and allow you to<br>ding your care" covered  |                     |  |       |                          |
|   | if he was in pain. He right side, leg and know rate it at an 8 out of 1 a 9 in the mornings. he did not get his Nor He stated, "If I don't gwas asked if his Norce stated it was and ther  | o.m., the resident was asked stated he had pain in his ee. She stated he would o. He stated it was usually He was asked how he felt if too when he requested it. let them, I get mad." He o was ever withheld. He in stated he would not bloyee was that withheld the |                     |  |       |                          |
|   | Norco. She stated, "I'the time." She stated because when he ask protocol I have to followould give the same in her statement. She take their pain as the   | arding LPN #3 withholding<br>Norco is what he asks for all  |                     |  |       |                          |
|   | Resident #7 was and diagnoses which incluance anxiety disorder.  | dmitted to the facility with uded convulsions and   |                     |  |       |                          |
|   |  | ssessment, dated 02/18/21,<br>lent's cognition was severely   |                     |  |       |                          |
|   | A state incident repor   | t form, dated 02/23/21,   |                     |  |       |                          |

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|   | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION |   |         | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|----------------------------|---|---------|-------------------------------|--|
|   |   |   | A. BUILDING: _             |   |         |                               |  |
|   |   | NH2407  | B. WING                    |   | I       | C<br>/ <b>01/2021</b>         |  |
|   |   |   |                            |   | 1 07    | 01/2021                       |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STAT         |   |         |                               |  |
| THE COMMONS 301 SOUTH OAKWOOD ROAD ENID, OK 73706 |   |   |                            |   |         |                               |  |
| 040.15  | CHMMADV CT  |   |                            | DDOVIDED'S DI ANI OF CODDI  | CCTION  | 245                           |  |
| (X4) ID<br>PREFIX<br>TAG                          | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETE<br>DATE      |  |
| LL815   | Continued From page   | e 141   | LL815                      |   |         |                               |  |
|   | Abuse/Mistreatment IncidentAdministrate allegation of verbal at from a staff member a is not on the schedule not be working until the investigated. Investig day and final reports, of the investigationa implemented to prevent attached for investigation resident. She was sure ways to recognize but a Employee Assistance.  The facility failed to rewithin two hours to the | or was notified today of an ouse occurring on 02/22/21 against a nurse. The nurse of until Thursday. She will not allegation has been gation is in progressFor 5 please include a summary and corrective measures ent recurrenceSee tion: Nurse yelled at ispended and counseled on rnout. Also gave her  |                            |   |         |                               |  |
|   | documented, "The da spent a majority of the hallway outside of [ar approximately 2 p.m. himself in his wheelch station area and park outside of the wound Immediately the chargand yelled to [residen here, you're not going here." [Resident #7] yelled at [LPN #3]. It is to health conditions. again "get the hell out talk to me that way." [resident #7] wheeled             | y CMA #3, dated 02/23/21, y of 2-22-21, [resident #7] e day sitting in the North Hall nother resident]s room. At [resident #7] wheeled hair up closer to the nurse's ed himself in his wheelchair care nurse's office. ge nurse, [LPN #3], stood up t #7] "get the hell out of y to sit up here while I'm did raise his hands and do not know what he yelled often hard to make out due [LPN #3] then yelled at him to fhere, you're not going to After this occurrence, himself away from the tack down the hall towards |                            |   |         |                               |  |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE C     |  |                                | E SURVEY<br>PLETED       |
|--------------------------|---|---|---------------------|--|--------------------------------|--------------------------|
| 7.11.2.1.27.11           | 0. 002011011  | .52   | A. BUILDING:        |  |                                |                          |
|                          |   |   | D MING              |  |                                | С                        |
|                          |   | NH2407  | B. WING             |  | 07                             | //01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AL   | ODRESS, CITY, STATE | E, ZIP CODE  |                                |                          |
| TUE 001                  |   | 301 SOU   | TH OAKWOOD RO       | DAD  |                                |                          |
| THE COM                  | IMONS   | ENID, OK  | 73706               |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815                    | Continued From page   | e 142   | LL815               |  |                                |                          |
|                          | his roomDuring this   | occurrence, [CMA #4] was<br>de me and witnessed the   |                     |  |                                |                          |
|                          | documented, "On Mo #4] came into work I was sitting at nurses statio came strolling up to the nurses station [LPN # around and go back it said I dont care Im not and he said he wanted screamed at him and your [sic] not sitting undeal with your Ass. so | y CMA #4, dated 02/24/21, inday February 22nd I [CMA was on North Hall. I was on [resident #7] the resident he Common Area by the #3] the nurse told him to turn he said he has rights She of gonna [sic] deal with you ed to sit up here She said "I dont give a dam [sic] p here Im not gonna [sic] to [resident #7] sat in the ft he was very upset the rest |                     |  |                                |                          |
|                          | documented, "The ot<br>getting something wh<br>at [resident #7]. And<br>[Resident #7] started<br>#3] got louder and tol   | y CNA #3, dated 02/24/21,<br>her day I was in the office<br>en I heard [LPN #3] yelling<br>telling him to go to his room.<br>yelling back at her and [LPN<br>d him she wasn't going to<br>r room. [LPN #3] then said<br>like this"  |                     |  |                                |                          |
|                          | 5:00 p.m., documente [administrator (admin back [and] was told the against me for yelling Monday February 22t [approximately] [2:00 the man but suppose [admin] via the came told I told male reside hall or go to his room                                 | y LPN #3, dated 02/24/21 at ed, "Missed a call from )] [at] the Commons. Called here was an allegation I [at] a male on North Hall on had [at] approx p.m.]Not only did I yell [at] dly I cussed [at] him also per ras. No AudioWas also ent to go away, go down the I had asked residents not round care Nurse's office as                                     |                     |  |                                |                          |

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Oklahoma State Department of Health

|                          | T OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE C     | CONSTRUCTION  | I \ /                        | E SURVEY                 |
|--------------------------|---|--|---------------------|---|------------------------------|--------------------------|
| AND PLAN                 | OF CORRECTION   | IDENTIFICATION NUMBER:                                     | A. BUILDING:        |   | COM                          | PLETED                   |
|                          |   |  |                     |   |                              | С                        |
|                          |   | NH2407   | B. WING             |   | 07                           | 7/01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STATE | E. ZIP CODE   |                              |                          |
|                          |   |  | TH OAKWOOD RO       |   |                              |                          |
| THE COM                  | MONS  | ENID, OF   |                     |   |                              |                          |
| (V4) ID                  | SLIMMARY ST.  | ATEMENT OF DEFICIENCIES                                    |                     | PROVIDER'S PLAN OF CO   | DRRECTION                    | (VE)                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTIOI<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815                    | Continued From page   | e 143  | LL815               |   |                              |                          |
|                          | it congests the hallwa<br>towards the resident  | ayMay of raised my voice<br>"                              |                     |   |                              |                          |
|                          | A investigative summ  | ary, undated, documented,                                  |                     |   |                              |                          |
|                          |   | orted victim[resident                                      |                     |   |                              |                          |
|                          |   | eported perpetrator[LPN                                    |                     |   |                              |                          |
|                          |   | the incident[CMA #3],                                      |                     |   |                              |                          |
|                          | [CNA #3], [CMA #4]  |  |                     |   |                              |                          |
|                          | happenedResidentwas in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the deskWhat is the history of the |  |                     |   |                              |                          |
|                          |   |  |                     |   |                              |                          |
|                          |   |  |                     |   |                              |                          |
|                          | ` '   | incident foreseeableThe                                    |                     |   |                              |                          |
|                          |   | oreaks lately, but there is NO                             |                     |   |                              |                          |
|                          |   | er should yell at a resident.                              |                     |   |                              |                          |
|                          |   | d Never yell at resident, but foreseeableWhat does the     |                     |   |                              |                          |
|                          |   | n[resident #7] would not                                   |                     |   |                              |                          |
|                          |   | but when asked what he                                     |                     |   |                              |                          |
|                          | would like to happen,   |  |                     |   |                              |                          |
|                          | shoulderWhen did t  | he incident happenAround                                   |                     |   |                              |                          |
|                          |   | y] 22ndWhen was facility                                   |                     |   |                              |                          |
|                          | , , , ,   | nent staff first contacted                                 |                     |   |                              |                          |
|                          | about the incidentO   | n Feb 23rd"  |                     |   |                              |                          |
|                          | An Oklahoma Board   | of Nursing complaint form,                                 |                     |   |                              |                          |
|                          |   | /21, documented, "Nurse's                                  |                     |   |                              |                          |
|                          |   | incident include Misconduct                                |                     |   |                              |                          |
|                          | or Criminal Behavior.   | Yes: Patient   |                     |   |                              |                          |
|                          |   | f InvestigationLPN was                                     |                     |   |                              |                          |
|                          | suspended pending the   | S .  |                     |   |                              |                          |
|                          |   | 2/26/2021. She received                                    |                     |   |                              |                          |
|                          |   | te up for raising her voice at                             |                     |   |                              |                          |
|                          | contrary to recognize   | nducting herself in a manner                               |                     |   |                              |                          |
|                          |   | cility is being retained"                                  |                     |   |                              |                          |
|                          |   | , <u>g</u> <del> </del>                                    |                     |   |                              |                          |
|                          |   | period from 02/14/21 to                                    |                     |   |                              |                          |
|                          | *   | d LPN #3 worked til 6:48                                   |                     |   |                              |                          |
|                          | p.m. on 02/22/21. LP  | PN #3 worked approximately                                 |                     |   |                              |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` '   | (X2) MULTIPLE CONSTRUCTION (X: A. BUILDING: |   |           |                          |
|---|---|---|---|---|-----------|--------------------------|
|   |   |   | A. Boilbillo.                               |   |           | С                        |
|   |   | NH2407  | B. WING                                     |   |           | /01/2021                 |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE                         | , ZIP CODE  |           |                          |
| TUE 001   |   | 301 SOU   | TH OAKWOOD RO                               | AD  |           |                          |
| THE COM   | IMONS   | ENID, OF  | C 73706                                     |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                         | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| LL815   | Continued From page   | e 144   | LL815                                       |   |           |                          |
|   | 4 hours and 48 minut  | es after the abuse occurred.  |   |   |           |                          |
|   | The facility failed to p abuse during the inve  | rotect residents from further estigation.   |   |   |           |                          |
|   |   | eport the allegation timely to a thorough investigation   |   |   |           |                          |
|   | to describe the incide 02/22/21 with resident resident is hard of her didn't yell. She stated took statements from and discussed the incidence of the was asked 02/22/21. She stated asked when the incidence stated she was notified was asked what the cowas. She stated it would it. She stated it would it. She stated she write up. She was astolerance for abuse. hand book is wrong." done to protect and p to other residents. She anything else other the was asked who the stabuse to. She stated asked when the staff did they report timely asked if the staff who in serviced about report." | t #7. She stated the aring and LPN #3 stated she d she reviewed the cameras, the witnesses and LPN #3 sident with the resident's when LPN #3 worked on she didn't know. She was ent was reported. She ad on the following day. She outcome of her investigation as substantiated that LPN #3 was suspended and had a ked if the facility had a zero She stated, "If I say yes, my She was asked what was revent this from happening the stated they didn't add than what was in place. She staff can report suspected part of the properties of the stated, "No." She was witnessed the abuse were orting timely. She stated, |   |   |           |                          |
|   | verbal abuse happen   | o.m., the DON was asked if<br>ed on 02/22/21 around 2:00<br>s." She was asked if LPN #3   |   |   |           |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION   |                      | (X3) DATE SURVEY<br>COMPLETED  |                 |
|---|--|--|----------------------|--|-----------------|
| ANDILAN   | or connection  | IDENTIFICATION NOMBER.   | A. BUILDING: _       |  |                 |
|   |  | NH2407   | B. WING              |  | C<br>07/01/2021 |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, STA     | TE, ZIP CODE   |                 |
| THE COM   | MONS   | 301 SOUT<br>ENID, OK   | H OAKWOOD F<br>73706 | ROAD   |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE  |
| LL815   | continued to work after was asked if LPN #3 residents, how were it stated," They couldn't about it." She was as report the abuse immediated. She stated. The ADM was asked after the incident. She staff members we not immediately report worked with the victin approximately four how the facility did not purplace to prevent abuse result, one of the with allegation of verbally. The facility substantiaterminated CMA #4 we employed by the facil. The facility failed to concurate investigation abuse.  3. Resident #5 was and diagnoses which included and commented the residually decision making. An initial incident reports. | er. She stated, "Yes." She continued to work with the resident protected. She to be, because we didn't know sked, since the staff failed to lediately, were the residents d, "No."  if the resident was assessed the stated, "No."  tho witnessed the abuse didn't it. As a result, LPN #3 in and other residents for burs and 48 minutes.  It any corrective measures in the from reoccurring. As a messes [CMA #4] had an abusing a different resident. The allegation and while LPN #3 continued to be lity.  complete a through and into the allegation of verbal different resident.  It also a session of the facility with the ded dementia.  It is sessment, dated 05/02/21, dent's cognitive skills for government, dated 06/07/21, dentInvolved[Resident Allegations of Description of series in the resident and the series in the series in the resident and the series in the resident and the series in the ser | LL815                |  |                 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  |                      | (X3) DATE SURVEY<br>COMPLETED   |       |                          |
|---|--|---|----------------------|---|-------|--------------------------|
| ANDILAN   | or connection  | IDENTIFICATION NOMBER.  | A. BUILDING: _       |   | COMIL | LILD                     |
|   |  | NH2407  | B. WING              |   | 07/0  | ;<br>1/2021              |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STA     | TE, ZIP CODE  |       |                          |
| THE COM   | MONS   | 301 SOUT<br>ENID, OK  | H OAKWOOD I<br>73706 | ROAD  |       |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE    | (X5)<br>COMPLETE<br>DATE |
| LL815   | A written statement fr 06/07/21, documente #2] asked me if I coul yes just give me a se middle of taking care I walked into [residen ahold [sic] of his Righ on him while she was bare skin I yelled at way [and] she was lik dropped him back on his arm to get him up would take care of hir breakfast [and] told th just happened. When #2] she told her to state [resident #5]. When I [10:00 a.m.] I asked ir [and] I told [DON] who me she was not awar asked me to write out.  A written statement fr documented, "[CMA ayelled at [CNA #2] be me to help get him [resoom where she was at her states she saw at his left leg so I told finish him, I went to [thappened she said I never hurt anyone war room" | e staff member. Staff bending investigation"  from CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had at arm yanking [and] pulling a slapping at his left leg,-on t her to stop doing him that the what [and] just kind of the bed, she went to pull on I told her to just leave that I m. I brought him out for the Charge Nursewhat had the [LPN #2] talked to [CNA the say away from direct care of I seen [sic] D.O.Naround f [LPN #2] had talk to her at had happened She told the but now she is [and] | LL815                |   |       |                          |
|   |  | dent #5] was awake. So<br>m up. got his clothes ready   |                      |   |       |                          |

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|  | OF DEFICIENCIES        | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE    | CONSTRUCTION   | (X3) DATE SURV |      |
|--|------------------------|--|------------------|--|----------------|------|
| AND PLAN   | OF CORRECTION          | IDENTIFICATION NUMBER:                                     | A. BUILDING: _   | A. BUILDING:   |                | D    |
|  |                        |  |                  |  | С              |      |
|  |                        | NH2407   | B. WING          |  | 07/01/2        | 021  |
| NAME OF P  | ROVIDER OR SUPPLIER    | STREET AD  | DRESS, CITY, STA | ATE, ZIP CODE  |                |      |
| 301 SOUTH OAKWOOD  |                        |  |                  | ROAD   |                |      |
| THE COM  | MONS                   | ENID, OK   | 73706            |  |                |      |
| (X4) ID  | SUMMARY ST             | ATEMENT OF DEFICIENCIES                                    | ID               | PROVIDER'S PLAN OF CORRECT   | TON            | (X5) |
| PREFIX<br>TAG  | `                      | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) |                | DATE |
| LL815  | Continued From page    | e 147  | LL815            |  |                |      |
|  | then uncovered him s   | started talking to him while                               |                  |  |                |      |
|  |                        | sed. I started by putting [sic]                            |                  |  |                |      |
|  |                        | then i put his pants on.                                   |                  |  |                |      |
|  |                        | ospital gown off. got his shirt                            |                  |  |                |      |
|  |                        | n. then put the arm in as I                                |                  |  |                |      |
|  |                        | his shirt, I told him not to Bite                          |                  |  |                |      |
|  | me. got his head in th | ne whole [sic] [and] pull his                              |                  |  |                |      |
|  |                        | t him up By Putting my arm                                 |                  |  |                |      |
|  |                        | a sitting position while i                                 | • •              |  |                |      |
| have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help |                        |  |                  |  |                |      |
|  |                        |  |                  |  |                |      |
|  | _                      | tting dressed. Because he                                  |                  |  |                |      |
|  |                        | as patting hisleg to clam<br>ure [sic] it was ok. then     |                  |  |                |      |
|  |                        | eir [sic] saw i was trying to                              |                  |  |                |      |
|  |                        | d me Let him lay Back down                                 |                  |  |                |      |
|  | the [sic] she would ge |  |                  |  |                |      |
|  |                        | ne room and went the Break                                 |                  |  |                |      |
|  | •                      | ask me if i hit him I told                                 |                  |  |                |      |
|  | her no i was patting h | im to try come [sic] him                                   |                  |  |                |      |
|  |                        | me not go around him again.                                |                  |  |                |      |
|  | until told other wise  | "  |                  |  |                |      |
|  | An investigative sumr  | mary, undated, documented,                                 |                  |  |                |      |
|  | "Who isthe report      | ed victim[resident   |                  |  |                |      |
|  | #5]who isreported      | · · ·  |                  |  |                |      |
|  |                        | Allegation that CNA was                                    |                  |  |                |      |
|  |                        | s arm and slapping his                                     |                  |  |                |      |
|  | •                      | to protect the resident(s)                                 |                  |  |                |      |
|  |                        | taff member was told not go                                |                  |  |                |      |
|  |                        | ntil further notice by the then was suspended and          |                  |  |                |      |
|  | sent home pending in   | •  |                  |  |                |      |
|  |                        | story of the residentWas                                   |                  |  |                |      |
|  |                        | bleResident has a history                                  |                  |  |                |      |
|  | of being combative to  |  |                  |  |                |      |
|  | deliveredWhen did      |  |                  |  |                |      |
|  |                        | :30 a.m.]When was facility                                 |                  |  |                |      |
|  |                        | nent staff first contacted                                 |                  |  |                |      |
|  | about the incident[1   |  |                  |  |                |      |

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|               | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                    | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|---------------|---|---|--------------------|--|-------------------------------|
|               |   |   | A. BUILDING: _     |  |                               |
|               |   |   | D WING             |  | С                             |
|               |   | NH2407  | B. WING            |  | 07/01/2021                    |
| NAME OF P     | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STAT | TE, ZIP CODE   |                               |
| THE COM       | MONO  | 301 SOU   | TH OAKWOOD R       | ROAD   |                               |
| THE COM       | MONS  | ENID, OF  | 73706              |  |                               |
| (X4) ID       | SUMMARY ST.   | ATEMENT OF DEFICIENCIES   | ID                 | PROVIDER'S PLAN OF CORRECT   | ON (X5)                       |
| PRÉFIX<br>TAG | `   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG      | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |                               |
| LL815         | Continued From page   | e 148   | LL815              |  |                               |
|               | "A skin sweep was by two nurses with not Accused perpetrator of 06/07/2021 pending a 06/08/2021 she was of the Administrator. Shor what could be consulted a Rel Understanding Deme perpetrator was allow 06/08/2021"  CNA #2's time sheet, documented she wor a.m. to 10:04 a.m., at   | was suspended on an investigation. On counseled by the DON and he received verbal education sidered to be abuse. She has Training entitled intia. The accused red to return to work on dated 06/06/21 to 06/19/21, ked on 06/07/21 from 6:30 and from 10:36 a.m. to 11:37 from 8:27 a.m. to 1:27 p.m.,  |                    |  |                               |
|               | unsubstantiated even witness, and failed to   | _   |                    |  |                               |
|               | to describe her invest she would complete a and suspend staff, ta staff on the hall that the complete safe survey the section of the hall was asked if staff wor stated not always. Sinconsidered interviewing on other halls. She so ther staff but not other staff but not other staff but not other staff but the investigation. | p.m., the DON was asked igation process. She stated an incident report, remove ke statements from other he incident occurred and is on cognitive residents on the incident occurred. She reked the same hall. She he was asked if she ing other staff and residents tated she has interviewed er residents. She was stigation was started. She 10:00 a.m. She was asked |                    |  |                               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | ` '   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---------------------|---|-------------------------------|--------------------------|
|   |  |   | 7 11 2012211101 _   |   | C                             | :                        |
|   |  | NH2407  | B. WING             |   | 1                             | 1/2021                   |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STAT   | TE, ZIP CODE  |                               |                          |
| THE COM   | MONS   |   | TH OAKWOOD R        | COAD  |                               |                          |
|   | OLIMANA DV. OT   | ENID, OK  |                     | DDO//DEDIO DI AN OF CODDECTIO   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| LL815   | stated late on 06/07/2 thorough investigation stated, "I feel it was the resident was assed delayed injury. She sidelayed injury. She sidelayed injury. She stated lunch and when she resuspended and sent is she worked on 06/08/here at 8:30 a.m. to me Relias training then rewas asked what discipreceived. She stated about dementia, she and two and a half how was asked what corresplace to prevent further residents. She stated The DON stated she is the side of the stated she is th | n was completed. She 21. She was asked if a n was conducted. She norough." She was asked if essed after incident for tated, "No."  CNA #2 had worked on she left at 10:04 a.m. for  | LL815               |   |                               |                          |
|   | and she called the CN acknowledged staff di the incident in a time!  LPN #2 did not report immediately and as a work with other reside and a half to two and investigation was not interviewing other stati is unknown if other involved.  4. Resident #8 had d  | MA for help. She id not notify DON or ADM of y manner.  incident to the DON result, CNA #2 continued to ents for approximately one a half hours. A thorough completed by not ff and residents. As a result, residents had been iagnoses which included sacrum requiring a wound |                     |   |                               |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---------------------|--|-------------------------------|--------------------------|
|   |  |   | B. WING             |  |                               | С                        |
|   |  | NH2407  | B. WING             |  | 07                            | /01/2021                 |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREETA   | DDRESS, CITY, STATE | , ZIP CODE   |                               |                          |
| THE COM   | MONS   |   | TH OAKWOOD RO       | AD   |                               |                          |
|   |  | ENID, OF  | 13/06               |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETE<br>DATE |
| LL815   | Continued From page  | : 150   | LL815               |  |                               |                          |
|   | A time record for RN adocumented she work a.m.   | #2, dated 06/27/21,<br>ked from 5:33 p.m. to 5:39   |                     |  |                               |                          |
|   | A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, "She than [sic] began saying that she was raped by 50 females every 30 minutesStaff is not to go in her room by themselves. This was reported to administration per policy"  On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."  At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home." |   |                     |  |                               |                          |
|   |  |   |                     |  |                               |                          |
|   |  |   |                     |  |                               |                          |
|   |  |   |                     |  |                               |                          |
|   | documented, "Final of Abuse/Mistreatmen IncidentResident material being raped by 50 per was also saying we with when staff CMA gave [signs/symptoms] of particular day and final reports, of the investigationS  | akes allegation that she was ople every 30 minutes. She were trying to poison her her ultramNo S/S ohysical rape notedFor 5 please include a summary See attached |                     |  |                               |                          |
|   | A report summary, da completion 06/28/21 a   | te and time of report<br>at 5:10 p.m., documented,  |                     |  |                               |                          |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | . ,                 | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---------------------|--|-------------------------------|--|
| 7.11.2.1.2.11.1          | 5. GGT1257.1611   | .5  | A. BUILDING: _      | A. BUILDING:   |                               |  |
|                          |   | NH2407  | B. WING             |  | C<br>07/01/2021               |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADD  | DRESS, CITY, STA    | TE. ZIP CODE   |                               |  |
|                          |   |   | H OAKWOOD F         |  |                               |  |
| THE COM                  | MONS  | ENID, OK  | 73706               |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE                   |  |
| LL815                    | woman and 50 of thei happenedAccusation bugsWhat was done from further harmSt room 2 at a timeWh of the incidentNotificthe resident's current statusAssessment of 06/28/21When was supervisor/management about the incident1 A statement from RN "2305-2315 [11:05 pure began saying that the The bed was checked sign of bugs. She that she was raped. She allegations. She said woman and there is 5 She cannot really designing in her room with being told by Administin with 2 Licensed number of the said woman and the said woman and the said woman and the said woman and there is 5 She cannot really designing in her room with being told by Administin with 2 Licensed number of the said everyone has been rabeen raped every 30 A statement, dated 06 documented, "Reside abused and raped regions." | orted perpetrator(s)A mWhat on of Rape and bed the to protect the resident(s) aff was to always go in at was done upon discovery the AdministratorWhat is physical done at 5PM facility the staff first contacted 1:47 PM [06/27/21]"  #2 documented, the man bed bugs in her bed. If by 2 staff and found no the staff began saying that the was been yelling these that the rapest [sic] is a the of them every 5 minutes. The of them every 5 minutes. The of them is a people and then after tration we have been going trees"  A #5, dated 06/28/21 at the d, "At 11:14 pm [Resident the ortly after she started d she was raped and that the orthy after she started d she was raped and that the orthy after she started d she said that she has minutes by 50 people" | LL815               |  |                               |  |
|                          | documented, "On 6   | -28-2021, resident in RM umberl has been velling  |                     |  |                               |  |

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|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | ' '                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |               |  |
|--------------------------|---|--|---------------------|--|---------------|--|
|                          |   |  | A. BOILDING.        |  | С             |  |
|                          |   | NH2407   | B. WING             |  | 07/01/2021    |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, STA   | TE, ZIP CODE   | -             |  |
| TUE 00M                  | MONO  | 301 SOU  | TH OAKWOOD F        | ROAD   |               |  |
| THE COM                  | WONS  | ENID, OF   | 73706               |  |               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETE |  |
| LL815                    | Continued From page   | e 152  | LL815               |  |               |  |
|                          | Rape multiple times a coming"   | and saying the police are  |                     |  |               |  |
|                          | had received a text m<br>nurse last night at 11:  | a.m., the ADM stated she dessage from the charge and the stated the had alarmed. The ADM deading the text  |                     |  |               |  |
|                          | On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a thorough investigation had been conducted and appropriate corrective actions were taken for allegation of abuse.  |  |                     |  |               |  |
|                          | A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse. |  |                     |  |               |  |
|                          | resident #7 on 02/22/<br>02/23/21, one day aft  | being verbally abusive to 21 was not reported until er the allegation occurred. ot protected as the staff to work.                               |                     |  |               |  |
|                          | being physically abus<br>reported by staff. The<br>resident, complete a t   | ed an incident of resident #5 sed by staff witnessed and e facility failed to protect the thorough investigation and measures to prevent further |                     |  |               |  |
|                          |   | allegation of rape by staff<br>staff had been allowed to<br>six hours after the  |                     |  |               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--|--|-------------------------------|--|
|  |   | A. BOILDING                              |  |                               |  |
|  | NH2407  | B. WING                                  |  | C<br>07/01/2021               |  |
| NAME OF PROMINED OR OURSELIES  | OTDEET AD   |  | TE 310 000E  |                               |  |
| NAME OF PROVIDER OR SUPPLIER   |   | DRESS, CITY, STA                         |  |                               |  |
| THE COMMONS  | ENID, OK  | H OAKWOOD F                              | ROAD   |                               |  |
| (X4) ID SUMMARY STAT   | EMENT OF DEFICIENCIES   | ID                                       | PROVIDER'S PLAN OF CORRECTION  | N (X5)                        |  |
| PREFIX (EACH DEFICIENCY I  | MUST BE PRECEDED BY FULL<br>C IDENTIFYING INFORMATION)  | PREFIX<br>TAG                            | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE                   |  |
| LL815 Continued From page 1  | 153   | LL815                                    |  |                               |  |
| allegation was made.   |   |  |  |                               |  |
| Staff witnessed verbal a an employee and report not reported to the admithorough investigation were residents were not protect perpetrator remaining a work while the investigt.  At 11:04 a.m., the Oklal Health (OSDH) was not existence of the IJ situal.  At 11:28 a.m., the Admit notified of the IJ.  An acceptable plan of rethe administrator on 06, documented the following "All residents will be intestaff on shift will be eduling immediately, and if not inserviced by phone cat 06/25/2021. (see attaction 06/26/2021) | was not conducted. The ected due to the et work and continued to tion was on going.  homa State Department of tified and verified the ation.  inistrator (ADM) was  removal was provided by 1/25/21 at 9:55 p.m. It ing:  erviewed 06/25/2021. All icated on updated policy currently working will be ill by midnight on ned) (amended to be 9 am |  |  |                               |  |
| ** if unable to be contact<br>date and time, and the<br>off the schedule until co  | staff member will be taken  |  |  |                               |  |
| The following texts will immediatelySurveyors deficiencies in Abuse re required to complete in-  | be sent to all staff<br>s have identified serious<br>eporting. All staff are<br>-service. Someone from  |  |  |                               |  |
| The Commons will be of tonightIf you have been complete an in-service of nursing] or will be rescheduleBeginning IN  | calling you before midnight<br>en not contacted to<br>by midnight, call [director   |  |  |                               |  |

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| Okianom       | a State Department of   | i icaili i   |                  |  |               |                  |
|---------------|-------------------------|--|------------------|--|---------------|------------------|
| STATEMENT     | OF DEFICIENCIES         | (X1) PROVIDER/SUPPLIER/CLIA                        | (X2) MULTIPLE    | CONSTRUCTION   | (X3) DATE S   | SURVEY           |
| AND PLAN (    | OF CORRECTION           | IDENTIFICATION NUMBER:                             | A. BUILDING:     |  | COMPLI        | ETED             |
|               |                         |  |                  | _  | _             | ,                |
|               |                         |  | B. WING          |  | C             |                  |
|               |                         | NH2407   | D. WING          |  | <u>ı 07/0</u> | )1/2021          |
| NAME OF PI    | ROVIDER OR SUPPLIER     | STREET AD  | DRESS, CITY, STA | ATE, ZIP CODE  |               |                  |
|               |                         | 301 SOUT   | H OAKWOOD        | ROAD   |               |                  |
| THE COM       | MONS                    | ENID, OK   |                  |  |               |                  |
|               |                         | ·  | 10700            |  |               | T                |
| (X4) ID       |                         | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID               | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD |               | (X5)<br>COMPLETE |
| PREFIX<br>TAG | ,                       | SC IDENTIFYING INFORMATION)                        | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APPROPR                              |               | DATE             |
|               |                         |  |                  | DEFICIENCY)  |               |                  |
| 11045         | 0 " 15                  | 454  | 11.045           |  |               |                  |
| LL815         | Continued From page     | 2 154  | LL815            |  |               |                  |
|               | or called to [administr | ator][assistant                                    |                  |  |               |                  |
|               |                         | s any time- DAY or NIGHT!                          |                  |  |               |                  |
|               | _                       | xt, then CALLAll staff that                        |                  |  |               |                  |
|               | •                       | as not timely reporting abuse                      |                  |  |               |                  |
|               |                         | suspension. [Resident #5]                          |                  |  |               |                  |
|               |                         | nysical abuse allegation will                      |                  |  |               |                  |
|               |                         | iately. At every allegation of                     |                  |  |               |                  |
|               |                         | ent to all staff to remind                         |                  |  |               |                  |
|               | 1                       | se very seriouslyAn                                |                  |  |               |                  |
|               |                         | eported, this is a reminder                        |                  |  |               |                  |
|               | _                       | ill be tolerated Administrator,                    |                  |  |               |                  |
|               |                         |  |                  |  |               |                  |
|               |                         | d DON have learned that a                          |                  |  |               |                  |
|               |                         | n includes resident safe                           |                  |  |               |                  |
|               | _                       | at the alleged abuser has                          |                  |  |               |                  |
|               |                         | statements from those                              |                  |  |               |                  |
|               | II = '='                | included in an investigation.                      |                  |  |               |                  |
|               | We have reviewed the    | * *  |                  |  |               |                  |
|               |                         | nd will follow our policies                        |                  |  |               |                  |
|               |                         | ed. We will in-service all                         |                  |  |               |                  |
|               |                         | attached education. We                             |                  |  |               |                  |
|               |                         | ess is the person that has                         |                  |  |               |                  |
|               | II                      | during the investigation. We                       |                  |  |               |                  |
|               |                         | ly assess the resident we                          |                  |  |               |                  |
|               |                         | l, psychosocial, and mental                        |                  |  |               |                  |
|               | status assessment at    | the time, and an                                   |                  |  |               |                  |
|               | assessment each shit    | ft for 3 days for 9                                |                  |  |               |                  |
|               | occurrences"            |  |                  |  |               |                  |
|               |                         |  |                  |  |               |                  |
|               |                         | e aides (CNA), seven                               |                  |  |               |                  |
|               |                         | ides (CMA), six licensed                           |                  |  |               |                  |
|               | practical nurses (LPN   | ), one registered nurse                            |                  |  |               |                  |
|               | (RN), seven houseke     | epers and one                                      |                  |  |               |                  |
|               | maintenance staff from  | m across all shifts, were                          |                  |  |               |                  |
|               | interviewed and able    | to state accurate information                      |                  |  |               |                  |
|               | related to abuse.       |  |                  |  |               |                  |
|               |                         |  |                  |  |               |                  |
|               |                         | I was asked what the facility                      |                  |  |               |                  |
|               |                         | the administrative staff on                        |                  |  |               |                  |
|               |                         | ne looked through the state                        |                  |  |               |                  |
|               | operations manual an    | nd reached out to some of                          |                  |  |               |                  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ' '   | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: |   |                                   |                          |
|---|--|---|---|---|-----------------------------------|--------------------------|
|   |  |   | A. BOILDING.                                |   |                                   |                          |
|   |  | NH2407  | B. WING                                     |   | 07                                | C<br><b>7/01/2021</b>    |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE                         | ZIP CODE  | ,                                 |                          |
| TO WILL OF T  | NOVIDER OR SOLVE LIER  |   | TH OAKWOOD RO                               |   |                                   |                          |
| THE COM   | MONS   | ENID, OF  |   |   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815   |  | e 155<br>ims online. She was asked  | LL815                                       |   |                                   |                          |
|   | information themselve was anything specific  | She stated they looked up es. She was asked if there  |   |   |                                   |                          |
|   | staff contnued to wor<br>allegation. A staff me<br>had been refusing/wit   | staff on 06/28/21 and the<br>k over six hours after the<br>ember alleged that LPN #3<br>thholding pain medications<br>illegation was not reported<br>rator and a thorough |   |   |                                   |                          |
|   | At 3:30 p.m., the administrator was made aware that an amended plan of removal was needed due to ongoing abuse and neglect allegations without protecting residents and conducting thorough investigations.  |   |   |   |                                   |                          |
|   |  | f removal was provided by<br>06/29/21 at 7:20 p.m. It<br>wing:  |   |   |                                   |                          |
|   | THESE items will be 2021 [By 8:00 p.m.] Misappropriation InveupdatedAn outside in-service on PRN [as administration for CM 30th. This inservice withholding medication been in serviced by Juntil in serviced, by the ADON [assistant diresting to the serviced of the s | estigation POLICY was   |   |   |                                   |                          |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | . ,  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|--|---|--|-------------------------------|--------------------------|
|   |   |  | 71. 201221110.                          |  | C                             |                          |
|   |   | NH2407   | B. WING                                 |  | 07/01/                        | 2021                     |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA                         | TE, ZIP CODE   |                               |                          |
| THE COM   | MONS  | 301 SOUTH<br>ENID, OK 1  | I OAKWOOD F                             | ROAD   |                               |                          |
| 0/0.15  | STIMMADA ST   | ATEMENT OF DEFICIENCIES  |   | PROVIDER'S PLAN OF CORRECTION  | N .                           | 0/5)                     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL815   | Continued From page   | e 156  | LL815                                   |  |                               |                          |
|   | 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21  |  |   |  |                               |                          |
|   | the INCIDENT RESP and includes the Adm Administrator, DON, A Center Resident serv administrator or design Director any allegation scheduled monthly manded in the Incident of | ADON, and HealthCare ices Director. The gnee will report to Board of n of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ng, and reporting/response anced traing on Abuse. To sidents, the INCIDENT eet to collaborate and is to ensure all thorough n completed." |   |  |                               |                          |
|   | On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.  |  |   |  |                               |                          |
|   | of 06/30/21 at 5:10 p.<br>plan of removal and the<br>had been implemente  | rdy deficiency was lifted as<br>m. when all elements of the<br>he amended plan of removal<br>ed. The deficient practice<br>f actual harm at a pattern.   |   |  |                               |                          |
|   | Based on record reviews, it was dete  | ew, resident and staff<br>ermined the facility failed to:  |   |  |                               |                          |
|   | <ul> <li>ensure a thorough<br/>completed and</li> </ul>   | investigation had been   |   |  |                               |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   |                     |  | X3) DATE SURVEY<br>COMPLETED |                  |
|---|--|---|---------------------|--|------------------------------|------------------|
|   |  |   | A. BUILDING:        | A. BUILDING:   |                              |                  |
|   |  |   | B. WING             |  |                              | С                |
|   |  | NH2407  | B. WING             |  | 07                           | //01/2021        |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | ZIP CODE   |                              |                  |
|   |  | 301 SOL   | JTH OAKWOOD RO      | AD   |                              |                  |
| THE COM   | MONS   | ENID, O   | K 73706             |  |                              |                  |
| (X4) ID   | SUMMARY ST   | ATEMENT OF DEFICIENCIES   | ID                  | PROVIDER'S PLAN OF                                     | CORRECTION                   | (X5)             |
| PREFIX<br>TAG   | ,  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | PREFIX<br>TAG       | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO DEFICIENCE | THE APPROPRIATE              | COMPLETE<br>DATE |
| LL815   | Continued From page  | e 157   | LL815               |  |                              |                  |
|   | abuse had been iden  | riate corrective actions when itified for six (#1, 5, 6, 7, 8 ed residents reviewed for   |                     |  |                              |                  |
|   | The facility identified facility.  | 95 residents resided in the   |                     |  |                              |                  |
|   | Findings:  |   |                     |  |                              |                  |
|   | "Reporting Requirem reported immediately and to other officials is law. Allegations that reported within 2 hou be thoroughly investig further potential abust progressappropriate including report to the boardPreventionI Commons that each abuse, neglectAll faupon first employmenthereafter, regarding. abuseImmediately abuse, neglect or mis supervisorThe superphone of the ADMINI DONSuspected or also be reported to restate agencies, law efamilies, and/or reside subject of abuse shall discussedInvestigation, treat and PROTE ADON, or house superported to the supervisor of abuse shall discussedInvestigation, treat and PROTE ADON, or house supervisions. | ed 12/08/2020, documented, entsallegations shall be to the administrator, DON in accordance with State involve abusemust be rsThese allegations must gated and must prevent se while the investigation is in e action must be taken appropriate licensing t [sic] the policy of The resident will be free from acility staff will be in-serviced int, and at least annuallyneglect or report any suspicion of streatment to your immediate ervisor WILL CALL the CELL STRATOR [admin], then the substantiated cases must espective agencies such as inforcement, physician; ent responsible party. The libe routinely and openly tionProcedure1stCare icT the resident-DON, ervisor should do a medical atelydocumenting any injury |                     |  |                              |                  |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| ` '                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|--|--|--|-------------------------------|--------------------------|
|                          |  |  | A. BUILDING: _                           |  |                               |                          |
|                          |  | NH2407   | B. WING                                  |  | 07/0                          | ;<br>1/2021              |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA                          | TE, ZIP CODE   |                               |                          |
| THE COM                  | MONS   | 301 SOUTH<br>ENID, OK 1  | I OAKWOOD F<br>73706                     | ROAD   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL815                    | Continued From page  | e 158  | LL815                                    |  |                               |                          |
|                          | resident2ndIsolate the perpetrator3rdImmediately notify the Administrator, then DON"   |  |  |  |                               |                          |
|                          | Resident #9 had d<br>chronic pain and oste   | iagnoses which included oarthritis.  |  |  |                               |                          |
|                          | A resident assessment documented the resident moderately impaired.   |  |  |  |                               |                          |
|                          | A care plan, effective date 01/07/21, documented, "Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndromeResident will have pain treated/relieved in a timely mannerAdminister medications as prescribed" |  |  |  |                               |                          |
|                          | "hydrocodone 7.5 mg<br>325 mg tablet (Norco  | ated 06/08/21, documented,<br>[milligrams]-acetaminophen<br>) give 1 tablet by oral route<br>ded FOR CHRONIC PAIN  |  |  |                               |                          |
|                          | Tylenol 325 mg capsuroute every 6 hours a  | ule give 2 tablets by oral s needed for pain   |  |  |                               |                          |
|                          | Ultram 50 mg tablet g<br>route every 6 hours a   | ive 1 tablet (50 mg) by oral<br>s needed for pain"   |  |  |                               |                          |
|                          | 12:35 a.m., documen on multiple occasions thing in the morning a [Resident #9] get up of ask for a pain pill. He Norco and rate his part butt pain. As protoco request to the charge go to the resident to e                             | A #3, dated 06/26/21 at ted, "Generally every day, s, typically beginning first after the CNA has helped out of bed for the day, he will be will specifically ask for a sin at an 8 out of 10 for leg or I, as the CMA, I report the nurse, the charge nurse will evaluate the resident and be CMA, with guidance to |  |  |                               |                          |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  |  | (X2) MULTIPLE       | (X3) DATE SURVEY  |             |
|--------------------------|--|--|---------------------|---|-------------|
| AND PLAN (               | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING:        |   | COMPLETED   |
|                          |  |  |                     |   | С           |
|                          |  | NH2407   | B. WING             |   | 07/01/2021  |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |             |
| THE COM                  | MONS   | 301 SOUTH  | I OAKWOOD I         | ROAD  |             |
| THE COM                  | WICHS  | ENID, OK   | 73706               |   |             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE |
| LL815                    | Continued From page 159  |  | LL815               |   |             |
|                          | administer a pain med level of the pain that valued in the pain that valued in the pain that valued in the pain pain meds stated a pain passon in the pain pain pain pain pain pain pain pill because he had no pain pill because he had no some pain meds until some pain meds until some p.m. as reflected on the administration record.  An OSDH incident for documented, "[Resign Abuse/Mistreatment   | d and instruct me with the was reported and the n. On many occurrences, e resident, [Resident's ting 'He just got up, he ill' or 'He's going outside to 's not hurting bad enough if smoke' or 'He can't have a nasn't eaten anything yet.' s, [Resident] won't receive times 10 a.m. or as late a 2 he MAR [medication  " |                     |   |             |
|                          | A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet"  Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications.  The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m. |  |                     |   |             |
|                          | The employee continuinvestigation of the al  | ued to work during the leged neglect.  |                     |   |             |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | <b>\</b> '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED  |                          |
|---|---|--|--|--|--------------------------------|--------------------------|
|   |   |  |  |  |                                | С                        |
|   |   | NH2407   | B. WING                                  |  | 07                             | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STATE                      | , ZIP CODE   |                                |                          |
| THE COM   | IMONS   |  | TH OAKWOOD RO                            | AD   |                                |                          |
|   | T   | ENID, OF   | K 73706                                  |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815   | Continued From page   | e 160  | LL815                                    |  |                                |                          |
|   | include the alleged vimedications being with medications being with medications being with medications being with medications being with medication of the investigation of the investigation of the investigation of the versus the Norco. Should administered the other nurses. She was documentation of the requested the Norco. you could tell when he asked if there was no resident requested it withheld the medicatic conclusion the allegations. | p.m., the administrator and or were asked about the estigation. The assistant she had made an excel nurse had given Tylenol ne stated the accused nurse medications as much as the   |  |  |                                |                          |
|   | There were no questi related to staff withhorstated the executive of surveys and thought members respect you make decisions regard that.  On 06/29/21 at 6:35 prif he was in pain. He right side, leg and known rate it at an 8 out of 1 a 9 in the mornings. he did not get his Nor  | In provided resident surveys.  In provided residents  In providents  In provided residents  In provided residents  In providents  In provided residents  In providents  In pr |  |  |                                |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                    |                          | (X3) DATE SURVEY<br>COMPLETED |   |  |
|---|--|---|--------------------|--------------------------|-------------------------------|---|--|
|   |  |   |                    |                          |                               | С |  |
| NH2407  |  |   | B. WING            | 07                       | 7/01/2021                     |   |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STAT | E. ZIP CODE              |                               |   |  |
|   |  |   | TH OAKWOOD R       |                          |                               |   |  |
| THE COM   | MONS   | ENID, OI  | K 73706            |                          |                               |   |  |
| (X4) ID<br>PREFIX<br>TAG  | X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE   |   |                    | (X5)<br>COMPLETE<br>DATE |                               |   |  |
| LL815   | Continued From page  | : 161   | LL815              |                          |                               |   |  |
|   | was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that withheld the medication.  |   |                    |                          |                               |   |  |
|   | Norco. She stated, "N the time." She stated because when he ask protocol I have to follo would give the same in her statement. She take their pain as they   | arding LPN #3 withholding<br>Norco is what he asks for all  |                    |                          |                               |   |  |
|   | <ol> <li>Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.</li> <li>A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.</li> </ol>                        |   |                    |                          |                               |   |  |
|   |  |   |                    |                          |                               |   |  |
|   | documented, "Incide Abuse/Mistreatment IncidentAdministrate allegation of verbal at from a staff member a is not on the schedule not be working until the investigated. Investigated and final reports, of the investigationa implemented to preveattached for investiga | or was notified today of an ouse occurring on 02/22/21 against a nurse. The nurse a until Thursday. She will be allegation has been leation is in progressFor 5 please include a summary and corrective measures and recurrenceSee tion: Nurse yelled at spended and counseled on |                    |                          |                               |   |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1` '   |                     |   | B) DATE SURVEY COMPLETED          |                          |
|---|---|--|---------------------|---|-----------------------------------|--------------------------|
|   |   |  | A. BUILDING:        |   |                                   |                          |
| NH2407  |   |  | B. WING             | -   | 07                                | C<br>7/ <b>01/2021</b>   |
| NAME OF D   | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STATE | ZIR CODE  |                                   |                          |
| NAIVIE OF P   | ROVIDER OR SUPPLIER   |  | TH OAKWOOD RO       |   |                                   |                          |
| THE COM   | MONS  | ENID, OK   |                     | AU  |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815   | Continued From page   | <del></del>  | LL815               |   | - ,                               |                          |
|   | Employee Assistance   |  |                     |   |                                   |                          |
|   | Limployee Assistance  | illioilliauoil   |                     |   |                                   |                          |
|   | The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).  |  |                     |   |                                   |                          |
|   |   |  |                     |   |                                   |                          |
|   | documented, "On Mo<br>#4] came into work I v<br>sitting at nurses static<br>came strolling up to the<br>nurses station [LPN #<br>around and go back h<br>said I dont care Im no<br>and he said he wante | y CMA #4, dated 02/24/21, nday February 22nd I [CMA was on North Hall. I was on [resident #7] the resident he Common Area by the #3] the nurse told him to turn he said he has rights She of gonna [sic] deal with you ad to sit up here She said "I dont give a dam [sic] |                     |   |                                   |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED   |               |  |
|---|---|---|---------------------|---|---------------|--|
|   |   |   | A. BOILDING.        |   | С             |  |
|   |   | NH2407  | B. WING             |   | 07/01/2021    |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, STA   | TE, ZIP CODE  |               |  |
|   |   |   | TH OAKWOOD F        |   |               |  |
| THE COM   | MONS  | ENID, OK  | 73706               |   |               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE |  |
| LL815   |   | e 163<br>p here Im not gonna [sic]<br>p [resident #7] sat in the                      | LL815               |   |               |  |
|   | _   | t he was very upset the rest  |                     |   |               |  |
|   | A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this"  A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from |   |                     |   |               |  |
|   |   |   |                     |   |               |  |
|   |   |   |                     |   |               |  |
|   |   |   |                     |   |               |  |
|   | back [and] was told th  | )] [at] the Commons. Called<br>nere was an allegation<br>[at] a male on North Hall on |                     |   |               |  |
|   | Monday February 22r [approximately] [2:00   | nd [at] approx<br>p.m.]Not only did I yell [at]                                       |                     |   |               |  |
|   | [admin] via the camer   | dly I cussed [at] him also per<br>ras. No AudioWas also<br>nt to go away, go down the |                     |   |               |  |
|   | hall or go to his room.   | . I had asked residents not<br>ound care Nurse's office as                            |                     |   |               |  |
|   | it congests the hallwa<br>towards the resident  | yMay of raised my voice<br>."   |                     |   |               |  |
|   | "Who is/are the rep   | ary, undated, documented, orted victim[resident                                       |                     |   |               |  |
|   | #3]Who witnessed t<br>[CNA #3], [CMA #4]  |   |                     |   |               |  |
|   | sitting near the nurse'   | was in his wheelchair<br>'s desk. [LPN #3] the nurse<br>nd started yelling at him to  |                     |   |               |  |
|   | leave the deskWhat  | t is the history of the   |                     |   |               |  |
|   | . ,   | incident foreseeableThe preaks lately, but there is NO                                |                     |   |               |  |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 164 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     |   | (X3) DATE SURVEY<br>COMPLETED  |                          |
|---|--|---|---------------------|---|--------------------------------|--------------------------|
|   |  |   |                     |   |                                | С                        |
| NH2407  |  |   | B. WING             |   | 07                             | 7/01/2021                |
| NAME OF P   | PROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, STATE | , ZIP CODE  |                                |                          |
| THE COM   | IMONS  | 301 SOU   | TH OAKWOOD RO       | AD  |                                |                          |
|   |  | ENID, OK  | 73706               |   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815   | reason a staff member A staff member shoul this incident was not victim want to happer discuss the incident, would like to happen, shoulderWhen did to 2pm on Feb [Februar supervisory/manager about the incidentC An Oklahoma Board submitted date 02/26 Name: [LPN #3]Did or Criminal Behavior. abuseDescription of suspended pending the returned to work on of disciplinary action writed a resident and for concontrary to recognize employment at the fact A time sheet for pay processed to 2/27/21, documented p.m. on 02/22/21. LF 4 hours and 48 minuted The facility failed to processed to the fail failed to processed to the fai | er should yell at a resident. d Never yell at resident, but foreseeableWhat does the n[resident #7] would not but when asked what he he just shrugged his the incident happenAround y] 22ndWhen was facility ment staff first contacted on Feb 23rd"  of Nursing complaint form, //21, documented, "Nurse's incident include MisconductYes: Patient f InvestigationLPN was he investigation and /2/26/2021. She received tte up for raising her voice at inducting herself in a manner d standards. Her cility is being retained"  period from 02/14/21 to d LPN #3 worked til 6:48 PN #3 worked approximately es after the abuse occurred. | LL815               | DEFICIENC   | τ)                             |                          |
|   | to describe the incide 02/22/21 with resident resident is hard of he   |   |                     |   |                                |                          |

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| Oklanoma State Department of Health |   |                                       |                   |                                 |              |          |
|-------------------------------------|---|---------------------------------------|-------------------|---------------------------------|--------------|----------|
| STATEMENT                           | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA           | (X2) MULTIPLE     | CONSTRUCTION                    | (X3) DATE SU | IRVEY    |
| AND PLAN (                          | OF CORRECTION   | IDENTIFICATION NUMBER:                | A. BUILDING:      | A. BUILDING:                    |              | TED      |
|                                     |   |                                       |                   | _                               |              |          |
|                                     |   |                                       | 5 14/11/0         |                                 | С            |          |
|                                     |   | NH2407                                | B. WING           | <del></del>                     | 07/01        | /2021    |
| NAME OF D                           | ROVIDER OR SUPPLIER   | STDEET AS                             | DDRESS, CITY, STA | TE 710 CODE                     |              |          |
| NAIVIE OF PI                        | ROVIDER OR SUPPLIER   |                                       | , ,               | ,                               |              |          |
| THE COM                             | MONS  | 301 SOU                               | TH OAKWOOD        | ROAD                            |              |          |
|                                     |   | ENID, OK                              | 73706             |                                 |              |          |
| (X4) ID                             | SUMMARY STA   | ATEMENT OF DEFICIENCIES               | ID                | PROVIDER'S PLAN OF CORRECTION   | 1            | (X5)     |
| PREFIX                              | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL            | PREFIX            | (EACH CORRECTIVE ACTION SHOULD  | BE           | COMPLETE |
| TAG                                 | REGULATORY OR I   | LSC IDENTIFYING INFORMATION)          | TAG               | CROSS-REFERENCED TO THE APPROPR | RIATE        | DATE     |
|                                     |   |                                       |                   | DEFICIENCY)                     |              |          |
| LL815                               | Continued From page   | e 165                                 | LL815             |                                 |              |          |
|                                     | 414-44- <i>6</i>  | 41                                    |                   |                                 |              |          |
|                                     |   | the witnesses and LPN #3              |                   |                                 |              |          |
|                                     |   | cident with the resident's            |                   |                                 |              |          |
|                                     |   | when LPN #3 worked on                 |                   |                                 |              |          |
|                                     |   | I she didn't know. She was            |                   |                                 |              |          |
|                                     |   | ent was reported. She                 |                   |                                 |              |          |
|                                     |   | ed on the following day. She          |                   |                                 |              |          |
|                                     |   | outcome of her investigation          |                   |                                 |              |          |
|                                     |   | as substantiated that LPN #3          |                   |                                 |              |          |
|                                     |   | e was suspended and had a             |                   |                                 |              |          |
|                                     |   | ked if the facility had a zero        |                   |                                 |              |          |
|                                     |   | She stated, "If I say yes, my         |                   |                                 |              |          |
|                                     | hand book is wrong."  | She was asked what was                |                   |                                 |              |          |
|                                     | done to protect and p   | revent this from happening            |                   |                                 |              |          |
|                                     | to other residents. Sh  | he stated they didn't add             |                   |                                 |              |          |
|                                     | anything else other th  | nan what was in place. She            |                   |                                 |              |          |
|                                     | was asked who the st  | taff can report suspected             |                   |                                 |              |          |
|                                     | abuse to. She stated  | , "Any authority." She was            |                   |                                 |              |          |
|                                     | asked when the staff  | had witnessed the abuse,              |                   |                                 |              |          |
|                                     | did they report timely.   | . She stated, "No." She was           |                   |                                 |              |          |
|                                     |   | witnessed the abuse were              |                   |                                 |              |          |
|                                     | in serviced about repo  | orting timely. She stated,            |                   |                                 |              |          |
|                                     | "Nothing in writing."   |                                       |                   |                                 |              |          |
|                                     | 0 0   |                                       |                   |                                 |              |          |
|                                     | On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00  |                                       |                   |                                 |              |          |
|                                     |   |                                       |                   |                                 |              |          |
|                                     |   | s." She was asked if LPN #3           |                   |                                 |              |          |
|                                     | •   | er. She stated, "Yes." She            |                   |                                 |              |          |
|                                     |   |                                       |                   |                                 |              |          |
|                                     | was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents |                                       |                   |                                 |              |          |
|                                     |   |                                       |                   |                                 |              |          |
|                                     |   |                                       |                   |                                 |              |          |
|                                     |   |                                       |                   |                                 |              |          |
|                                     | •   | <u> </u>                              |                   |                                 |              |          |
|                                     | protected. She stated   | u, INU.                               |                   |                                 |              |          |
|                                     | The ADM was sales   | if the resident was assessed          |                   |                                 |              |          |
|                                     |   |                                       |                   |                                 |              |          |
|                                     | after the incident. Sh  | e stated, "No."                       |                   |                                 |              |          |
|                                     | The staff war and an all  | ha wiking a paradiklar a bees a still |                   |                                 |              |          |
|                                     |   | ho witnessed the abuse did            |                   |                                 |              |          |
|                                     |   | rt it. As a result, LPN #3            |                   |                                 |              |          |
|                                     | worked with the victin  | n and other residents for             | 1                 |                                 |              |          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED  |                 |  |
|---|--|---|---------------------|--|-----------------|--|
|   |  |   | A. BOILDING.        | A. BUILDING.   |                 |  |
|   |  | NH2407  | B. WING             |  | C<br>07/01/2021 |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STA   | TE. ZIP CODE   | •               |  |
|   |  |   | TH OAKWOOD F        |  |                 |  |
| THE COM   | MONS   | ENID, OF  |                     |  |                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE  |  |
| LL815   | place to prevent abus result, one of the with allegation of verbally. The facility substantiaterminated CMA #4 wemployed by the facility failed to caccurate investigation abuse.  3. Resident #5 was a diagnoses which included a quarterly resident a documented the residually decision making.  An initial incident report | t any corrective measures in the from reoccurring. As a sesses [CMA #4] had an abusing a different resident. In the allegation and while LPN #3 continued to be a sity.  The allegation of verbal different resident into the allegation of verbal different resident.  The allegation and the allegation of verbal different resident.  The allegation of verbal different resident into the allegation of verbal different resident into the allegation of verbal different resident into the facility with added dementia.  The allegation of the allegation of verbal resident into the allegation of the allegation of the allegation into the allegation into the allegation into the facility with added dementia. | LL815               | DEFICIENCY)  |                 |  |
|   | IncidentReceived a towards a resident by member suspended p  | <del>-</del>  |                     |  |                 |  |
|   | #2] asked me if I coul yes just give me a se middle of taking care I walked into [residen ahold [sic] of his Righ on him while she was bare skin I yelled at way [and] she was lik   | om CMA #2, dated d "Around [8:30 a.m.] [CNA d come help her I told her cond because I was in the of another Resident. When t #5]'s room [CNA #2] had t arm yanking [and] pulling slapping at his left leg,-on ther to stop doing him that e what [and] just kind of the bed, she went to pull on  |                     |  |                 |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE  | (X3) DATE SURVEY<br>COMPLETED |   |                 |  |
|---|---|--|-------------------------------|---|-----------------|--|
| ANDILAN   | OF CONTLOTION   | IDENTIFICATION NOMBER.   | A. BUILDING: _                | COMILETED   |                 |  |
| NH2407  |   |  | B. WING                       | B WING  |                 |  |
|   |   |  |                               |   | 07/01/2021      |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STAT            |   |                 |  |
| THE COM   | IMONS   |  | TH OAKWOOD R                  | ROAD  |                 |  |
|   | _   | ENID, OF   | 73706                         |   |                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICENCY) | ULD BE COMPLETE |  |
| LL815   | Continued From page   | e 167  | LL815                         |   |                 |  |
|   | his arm to get him up would take care of hir breakfast [and] told the just happened. When #2] she told her to state [resident #5]. When It [10:00 a.m.] I asked it [and] I told [DON] what me she was not awar asked me to write out.  A written statement for documented, "[CMA #2] be me to help get him [restroom where she was at her states she saw at his left leg so I told finish him, I went to [6] happened she said I vold to the state of the said I vold finish him, I went to [6] happened she said I vold to the said I vold to the said I vold finish him, I went to [6] happened she said I vold to the said I vold to the said I vold finish him, I went to [6] happened she said I vold to the said I | I told her to just leave that I m. I brought him out for the Charge Nursewhat had the [LPN #2] talked to [CNA the away from direct care of the seen [sic] D.O.Naround the f[LPN #2] had talk to her the at had happened She told the but now she is [and]  |                               |   |                 |  |
|   | documented, "[residesided [sic] to get hithen uncovered him so was getting him dress his pull-up on the [sic after that I took his hor ready to put his arm i went to put his head I me. got his head in the shirt down. tried to si on leg to Push Leg in have my other hand a him sit up. then holle stand him to finish ge was fighting me. I was  | om CNA #2, dated 06/07/21, dent #5] was awake. So m up. got his clothes ready started talking to him while sed. I started by putting [sic] I then i put his pants on. ospital gown off. got his shirt in. then put the arm in as I his shirt, I told him not to Bite he whole [sic] [and] pull his thim up By Putting my arm a sitting position while i around upper back to help red [sic] at [CMA #2] to help tting dressed. Because he as patting hisleg to clamure [sic] it was ok. then |                               |   |                 |  |

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Oklahoma State Department of Health

| AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED    C   NH2407   B. WING   07/01/202  NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   | ĺ                        |
|--|--------------------------|
| NH2407  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE   |                          |
|  | 021                      |
| ANA COUTU CALCIDOS BOAR  |                          |
| THE COMMONS  301 SOUTH OAKWOOD ROAD  |                          |
| ENID, OK 73706   |                          |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM  | (X5)<br>COMPLETE<br>DATE |
| LL815 Continued From page 168 LL815  |                          |
| LL815  [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurseask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise"  An investigative summary, undated, documented, "Who isthe reported victim[resident #5]who isreported perpetrator[CNA #2]What happenedAllegation that CNA was yanking on Residents arm and slapping his legWhat was done to protect the resident(s) from further harmStaff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DONWhat is the history of the residentWas the incident foreseeableResident has a history of being combative to staff when cares are deliveredWhen did the incident happen060/72/1, [7:30 a m.]When was facility supervisory/management staff first contacted about the incident[10:00 a.m.]  A final state report, dated 06/08/21, documented, " A skin sweep was completed on the resident by two nurses with no injuries notedThe Accused perpetrator was suspended on 06/08/2021.**  O6/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021.** |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE  | (X3) DATE SURVEY<br>COMPLETED |   |                 |
|---|--|--|-------------------------------|---|-----------------|
|   |  |  | A. BUILDING: _                |   |                 |
|   |  | NH2407   | B. WING                       |   | C<br>07/01/2021 |
|   |  | 14112407   |                               |   | 07/01/2021      |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STAT            |   |                 |
| THE COM   | MONS   |  | TH OAKWOOD R                  | ROAD  |                 |
|   | -  | ENID, OF   | 73706                         |   |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE   |
| LL815   | Continued From page  | e 169  | LL815                         |   |                 |
|   | documented she worl<br>a.m. to 10:04 a.m., ar<br>a.m. and on 06/08/21<br>and from 1:57 p.m. to   | dated 06/06/21 to 06/19/21,<br>ked on 06/07/21 from 6:30<br>nd from 10:36 a.m. to 11:37<br>from 8:27 a.m. to 1:27 p.m.,<br>o 2:32 p.m.   |                               |   |                 |
|   | unsubstantiated even<br>witness, and failed to<br>investigation by interv<br>and residents.  | •  |                               |   |                 |
|   | to describe her invest she would complete a and suspend staff, tal staff on the hall that the complete safe survey the section of the hall was asked if staff wor stated not always. Street considered interviewing on other halls. She stated on 06/07/21 at when the investigation stated late on 06/07/2 thorough investigation stated, "I feel it was the the resident was assed delayed injury. She staff that the staff was assed to the staff of the staff was assed to the staff of the staff was assed to the staff of the staff was assed to the staff was asset to the staff was assed to the staff was as | ng other staff and residents tated she has interviewed er residents. She was stigation was started. She 10:00 a.m. She was asked in was completed. She 21. She was asked if a n was conducted. She norough." She was asked if essed after incident for stated, "No." |                               |   |                 |
|   | 06/07/21. She stated lunch and when she r suspended and sent I she worked on 06/08/here at 8:30 a.m. to n  | CNA #2 had worked on she left at 10:04 a.m. for returned, she was shome. She was asked when /21. She stated she was neet with DON and watch eturned to the floor. She  |                               |   |                 |

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STATE FORM 6899 C7JI11 If continuation sheet 170 of 227

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| A BUILDING:  NH2407  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706  ENID, OK 73706  PREFIX  TAG  COMPLETE  CROWNERS PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MIST BE PRECEDED BY FULL  TAG  CROSS-REFERNED TO THE APPROPRIATE  DEFICIENCY  Was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.  LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.  |
|--|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD EINID, OK 73706   (X4) ID PREFIX ITAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  LL815  Continued From page 170  LL815  Continued From page 170  LL815  Continued From page 170  LL815  LL815  LL815  LL815  LL815  LL816  LL815  LL816  LL817  LL816  LL817  LL818  LL81 |
| THE COMMONS  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  LL815  Continued From page 170  was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.  LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound   |
| CAJ   D   SUMMARY STATEMENT OF DEFICIENCIES  |
| PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DATE   |
| was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.  LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.  4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound   |
| A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.  A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.  A progress note, dated 06/28/21 at 4:23 a.m., documented, "She than [sic] began saying that she was raped by 50 females every 30 minutesStaff is not to go in her room by themselves. This was reported to administration per policy"  |

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| NAME OF PROVIDER OR SUPPLIER  A. BUILDING:  B. WING  O7/01/2021  | j                      |  |  |  |  |  |  |
|--|------------------------|--|--|--|--|--|--|
| NH2407 B. WING 07/01/2021  | C                      |  |  |  |  |  |  |
| ·  | 21                     |  |  |  |  |  |  |
|  |                        |  |  |  |  |  |  |
| 301 SOUTH OAKWOOD ROAD   |                        |  |  |  |  |  |  |
| THE COMMONS ENID, OK 73706   |                        |  |  |  |  |  |  |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP   | (X5)<br>MPLETE<br>DATE |  |  |  |  |  |  |
| LL815 Continued From page 171 LL815  |                        |  |  |  |  |  |  |
| On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."  At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."  An OSDH incident report, dated of 06/27/21, documented, "Final[Resident #8]. Allegations of Abuse/Mistreatment. Description of IncidentResident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultramNo S/S [signs/symptoms] of physical rape notedFor 5 day and final reports, please include a summary of the investigationSee attached  A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "Who is/are the reported perpetrator(s) A woman and 50 of themWhat happenedAccusation of Rape and bed bugsWhat was done to protect the resident(s) from further harmStaff was to always go in room 2 at a timeWhat was done upon discovery of the incidentNotified AdministratorWhat is the resident's current physical statusAssessment done at 5PM 06/28/21When was facility supervisor/management staff first contacted about the incident11:47 PM [06/27/21]" |                        |  |  |  |  |  |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE (  | (X3) DATE SURVEY<br>COMPLETED |   |                 |
|---|--|--|-------------------------------|---|-----------------|
|   |  |  | A. BUILDING:                  |   |                 |
|   |  | NH2407   | B. WING                       |   | C<br>07/01/2021 |
| NAME OF D   | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STATI           | E ZIR CODE  | 1 00            |
| NAME OF F   | ROVIDER OR SUFFLIER  |  | TH OAKWOOD R                  |   |                 |
| THE COM   | MONS   | ENID, OK   |                               |   |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETE |
| LL815   | Continued From page "2305-2315 [11:05] began saying that the The bed was checked sign of bugs. She that she was raped. She allegations. She said woman and there is 5 She cannot really des going in her room with being told by Adminis in with 2 Licensed nur  A statement from CN 12:32 p.m., document #8] started yellingS yelling rape. She said everyone has been ra been raped every 30  A statement, dated 06 documented, "Reside abused and raped rep  A statement, dated 06 documented, "On 6 [resident #8's room no Rape multiple times a coming"  On 06/28/21 at 6:27 a had received a text m nurse last night at 11: resident's wound vac was observed to be re from the charge nurse when the nurse went resident alleged rape | e. 172  D.m. to 11:15 p.m.] Resident are was bed bugs in her bed. If by 2 staff and found no an [sic] began saying that has been yelling these that the rapest [sic] is a 0 of them every 5 minutes. Scribe them Staff has been a 2 people and then after tration we have been going reses"  A #5, dated 06/28/21 at ted, "At 11:14 pm [Resident hortly after she started dishe was raped and that aped. She said that she has minutes by 50 people"  B/28/21, from CNA #7, ant stated she was being peatedly" | LL815                         |   |                 |
|   |  | The administrator stated she sk when it happened and   |                               |   |                 |

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STATE FORM 6899 C7JI11 If continuation sheet 173 of 227

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | , ,                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                                 |                          |
|--------------------------|---|---|---------------------|--|---------------------------------|--------------------------|
|                          |   |   | A. BUILDING:        |  |                                 |                          |
|                          |   | NH2407  | B. WING             |  | 07                              | C<br><b>//01/2021</b>    |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STAT  | E, ZIP CODE  |                                 |                          |
| THE COM                  | MONS  | 301 SOU   | TH OAKWOOD R        | OAD  |                                 |                          |
| THE COM                  | WONS  | ENID, OI  | K 73706             |  |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL815                    | Continued From page   | e 173   | LL815               |  |                                 |                          |
|                          | The nurse told the AD female rapist and 50  | hat the person looked like.  M the resident reported a people every 30 minutes.  If the ADM that the rapist                         |                     |  |                                 |                          |
|                          | with the resident last<br>She stated she had in<br>the family and physical<br>resident. She stated<br>assessed. The admin<br>nurse, "You can't rape<br>close to." She was as  | the resident refused to be nistrator stated she told the someone you can't get sked who the two staff were g with the resident. She |                     |  |                                 |                          |
|                          | residents once she wallegation of rape. She with two, always two. facility policy was for was an allegation of a find the policy." She reading it. She stated them, suspend." She two staff had been suat the time." She stated She was asked what She stated, "I don't kn She was asked if her | ions of abuse had been  |                     |  |                                 |                          |
|                          | regarding resident #8<br>reviewed with the AD<br>her report on the staff  | a.m., the investigation allegation of rape was M. She stated she based statements.  DM, her interview from                          |                     |  |                                 |                          |

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|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                  | CONSTRUCTION   | (X3) DATE SU<br>COMPLE |                          |
|--------------------------|--|--|----------------------|--|------------------------|--------------------------|
|                          |  |  | A. BOILDING.         |  | C                      |                          |
|                          |  | NH2407   | B. WING              |  | 1                      | /2021                    |
| NAME OF PRO              | OVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA      | TE, ZIP CODE   |                        |                          |
| THE COMM                 | ONS  | 301 SOUTH<br>ENID, OK 1  | I OAKWOOD I<br>73706 | ROAD   |                        |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE                     | (X5)<br>COMPLETE<br>DATE |
|                          | texted her that the resperpetrators as "looks investigative report do unable to give a descrives", referring to the information. She was concerned about the or "What does the report interview from yesterd reported to her the de "looks like us" and the resident was unable to There was no respons. The two employees refacility all night after the resident identifying the who raped her.  The facility failed to has investigation into the action of the resident assessment documented the resident A time record, dated the facility and from 5:42 and A nurse's note, dated documented, "Reside back" | reported the charge nurse sident described the silke us" and that the ocumented the resident was ription. The ADM stated, discrepancies in a saked if she was discrepancies. She stated, t say." Reviewed her day that she stated the nurse escription the resident stated a report documented the ocumented the ocumented working at the ne allegation of rape and the ne allegation of rape and the ne allegations.  Bayean accurate a thorough allegations. | LL815                |  |                        |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE C  |                     | (X3) DATE SURVEY<br>COMPLETED  |                 |
|---|--|--|---------------------|--|-----------------|
|   |  |  | A. BUILDING:        |  |                 |
|   |  | NH2407   | B. WING             |  | C<br>07/01/2021 |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AL  | ODRESS, CITY, STATE | E, ZIP CODE  |                 |
| THE COM   | MONS   | 301 SOU  | TH OAKWOOD RO       | OAD  |                 |
| THE COM   | WONS   | ENID, OK   | 73706               |  |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETE   |
| LL815   | Continued From page  | e 175  | LL815               |  |                 |
|   | director that activity a statement, that she or F****** Christ, [Reside notified he had fallen. The nurse is suspend complete" A facsim documented the repo 03/22/21 at 4:22 p.m.  There was no docume clinical record of the aresident.  The facility did not repto the Oklahoma Stat within the required two A time record for LPN worked on 03/23/21 find A final OSDH report, at 6:38 p.m., docume | ide reported to her in a verheard a nurse say "Jesus ent #6] really? when she was Nurse is not on shift today. Ided until investigation is nile (fax) cover sheet, rt was sent to the OSDH on entation in the resident's alleged abuse against the port the allegation of abuse to Department of Health to hours.  I #1 documented she from 5:42 a.m. to 2:34 p.m.  I faxed to OSDH on 03/23/21 anted the followingFor 5 please include a summary face Sheet attached, |                     |  |                 |
|   | on 03/23/21. The foll asked:   | onducted with three residents owing questions were   |                     |  |                 |
|   | light, you get everythi 2. Have you heard sta language? 3. Has staff ever yelle  | en you turn on your call ng you need taken care of? aff using inappropriate ed or spoken harsh to you? needs aren't met, do you were documented.   |                     |  |                 |
|   |  | rking after the allegation of<br>en made and throughout the  |                     |  |                 |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 176 of 227

Oklahoma State Department of Health

|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE       | CONSTRUCTION   | (X3) DATE SURVEY |
|--------------------------|--|--|---------------------|--|------------------|
| AND PLAN (               | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING: _      |  | COMPLETED        |
|                          |  |  | 5 14/110            |  | С                |
|                          |  | NH2407   | B. WING             |  | 07/01/2021       |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE   |                  |
| THE COM                  | MONS   |  | H OAKWOOD F         | ROAD   |                  |
|                          |  | ENID, OK   | 73706               |  |                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETE      |
| LL815                    | Continued From page  | e 176  | LL815               |  |                  |
|                          | investigation.   |  |                     |  |                  |
|                          | iiivooligatioii.   |  |                     |  |                  |
|                          | reporting staff member or other staff with the administrator document the staff member maked others. She documented reported hearing the member who had mandaministrator document incident did not occur. On 06/24/21 at 1:35 pwhen LPN #1 worked she worked til 3:21 p. did the LPN receive. She was asked when completed. She state completed, but the document of the staff of | ented that she had spoken to king the allegation and three inted she spoke with resident the only person who comments was the staff de the allegation. The ented her conclusion was the common that the conclusion was the common that the conclusion was asked to no 03/21/21. She stated in the DON stated, "None." The DON stated, "None." the investigation had been the common that the c |                     |  |                  |
|                          | and LPN #1. She wa worked during the inv   | flict between the activity aide<br>s asked if LPN #1 had<br>restigation. The DON<br>as asked what was put in   |                     |  |                  |
|                          | place to prevent reoc<br>residents. She stated<br>She was asked, how<br>protected if the LPN v   | currence and to protect the<br>I there were no changes.<br>residents had been<br>worked during the   |                     |  |                  |
|                          | re-interviewed and ha<br>the allegation could n<br>asked if was reported   | ated the complainant was ad a discussion about how ot have occurred. She was timely. She stated she was  |                     |  |                  |
|                          | not notified until the n   | ехт дау.   |                     |  |                  |
|                          | asked if she recalled<br>She stated she did. S<br>cursed at the residen  | a.m., the activity aide was<br>the incident on 03/21/21.<br>She stated LPN #1 had<br>t when she reported to her<br>ne stated, LPN #1 said,   |                     |  |                  |

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|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|------------------------------|---|-------------------------------|
|                          |  |  | A. BOILDING.                 |   | С                             |
|                          |  | NH2407   | B. WING                      |   | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA              | TE, ZIP CODE  |                               |
| THE COM                  | MONO   |  | OAKWOOD F                    |   |                               |
| THE COM                  | MONS   | ENID, OK   | 73706                        |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE                   |
| LL815                    | Continued From page  |  | LL815                        |   |                               |
|                          | "Jesus F*** Christ, [R<br>asked who she had re<br>stated she reported it   | esident]. Really." She was eported the incident to. She to her supervisor that day or was going to call the  |                              |   |                               |
|                          | investigation of abuse allegation of abuse ar  | rotect residents during an<br>e, thoroughly investigate an<br>nd failed to report the<br>nistrator and appropriate   |                              |   |                               |
|                          |  | dmitted to the facility with ided Parkinson's disease.   |                              |   |                               |
|                          |  | ssessment, dated 06/12/21,<br>ent's cognition was severely   |                              |   |                               |
|                          | I  | _  |                              |   |                               |
|                          | 6/12/2021ALLEGAT ABUSEOn June 12 11:00 am a incident w member in which a Reinvolved. CNA #1 rec shoe for her and she personal SnapChat st does your resident ev reason??" The captic laughing face emoji a was terminated for mi | d, "CNA #1wasYestermination date TONS/FACTS OF 2021 at approximately ras reported by a staff resident [resident #1] was rorded [resident #1] tying her roosted the video on her rory with the caption "But retie your shoes for no |                              |   |                               |

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Oklahoma State Department of Health

|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|---------------------|---|-------------------------------|
|                          |   |   | A. Boilebirto.      |   | С                             |
|                          |   | NH2407  | B. WING             |   | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, STA    | TE, ZIP CODE  |                               |
| TUE 00M                  | MONO  | 301 SOUT  | H OAKWOOD I         | ROAD  |                               |
| THE COM                  | MONS  | ENID, OK  | 73706               |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE                   |
| LL815                    | Continued From page   | : 178   | LL815               |   |                               |
|                          | when the staff were in phone use and social in serviced when they She was asked what media restrictions were anything about reside pictures. She stated cell phones in break rephone in resident area the staff were in service She stated they plant July. She stated they plant they had to wait for the updated policy. She was measures were put in | a.m., the DON was asked a serviced related to cell media. She stated they are are hired during orientation. The cell phone and social re. She stated not to post ints, the facility and no staff were only to have their oom and not to have a cell as. The DON was asked if ced related to the incident are on in servicing staff in were going to in June but eir board's approval of the was asked if any corrective place to protect the occurrence. She stated |                     |   |                               |
|                          | what staff were intervinvestigation. She stathey did not interview working that same shistaff members were not thorough investigation. "Guess not." She was protected from further they did not initiate an A thorough investigation related to this incident.  | ated CMA #1. She stated other staff who were iff. She was asked if other ot interviewed, was a n completed. She stated, s asked how residents were occurrence. She stated   |                     |   |                               |
| LL816                    |   | 2) BASIC NURSING AND  | LL816               |   |                               |
|                          | (b) Basic nursing and provided for residents  | personal care shall be as needed.   |                     |   |                               |

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|               | OF DEFICIENCIES OF CORRECTION                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:        | 1 ' '            | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|---------------|--|---|------------------|---|-------------------------------|
| ANDIEAN       | or contribution                                    | IDENTIFICATION NOMBER.                                    | A. BUILDING: _   |   | OOM! LETEB                    |
|               |  |   |                  |   | С                             |
|               |  | NH2407  | B. WING          |   | 07/01/2021                    |
| NAME OF PI    | ROVIDER OR SUPPLIER                                | STREET ADI  | ORESS, CITY, STA | TE, ZIP CODE  |                               |
|               |  |   | H OAKWOOD I      |   |                               |
| THE COM       | MONS   | ENID, OK  |                  |   |                               |
| (X4) ID       | SUMMARY STA  | ATEMENT OF DEFICIENCIES                                   | ID               | PROVIDER'S PLAN OF CORRECTION   | )N (X5)                       |
| PREFIX<br>TAG | (EACH DEFICIENC)                                   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE                 |
| LL816         | Continued From page                                | : 179   | LL816            |   |                               |
|               |  | I include, but not be limited                             |                  |   |                               |
|               | to:  | idents to be active and out                               |                  |   |                               |
|               | of bed for reasonable                              |   |                  |   |                               |
|               |  | ent temperature, blood                                    |                  |   |                               |
|               | , ,  | espirations at least once                                 |                  |   |                               |
|               |  | more frequently if warranted                              |                  |   |                               |
|               | by the resident's cond                             |   |                  |   |                               |
|               | recorded in the clinica                            |   |                  |   |                               |
|               |  | ent weight at least once                                  |                  |   |                               |
|               |  | more frequently if warranted                              |                  |   |                               |
|               | by the resident's cond<br>recorded in the clinical |   |                  |   |                               |
|               |  | ent pain whenever vital                                   |                  |   |                               |
|               | , ,  | nore frequently if warranted                              |                  |   |                               |
|               | by the resident's cond                             | •   |                  |   |                               |
|               | recorded in the clinical                           | al record.  |                  |   |                               |
|               |  | nd making fluids available,                               |                  |   |                               |
|               | to maintain proper hy                              |   |                  |   |                               |
|               |  | nutritional practices for                                 |                  |   |                               |
|               | diets, enteral and pare assistance in eating.      | enteral feedings and                                      |                  |   |                               |
|               | _  | skin care to prevent skin                                 |                  |   |                               |
|               | breakdown.   | Skiii care to prevent skiii                               |                  |   |                               |
|               | (F) Providing proper                               | body alignment.   |                  |   |                               |
|               |  | rtive devices to promote                                  |                  |   |                               |
|               | proper alignment and                               | positioning.  |                  |   |                               |
|               |  | dents every two hours or as                               |                  |   |                               |
|               |  | essure areas, contractures,                               |                  |   |                               |
|               | and decubitus.                                     | of mostion avancians in                                   |                  |   |                               |
|               |  | of motion exercises in idual assessment and care          |                  |   |                               |
|               | plans.   | iuuai assessiiieiil allu Gale                             |                  |   |                               |
|               | (J) Ensuring that res                              | idents positions are                                      |                  |   |                               |
|               | ` ,  | ours or as needed when in a                               |                  |   |                               |
|               | chair and are toileted                             |   |                  |   |                               |
|               |  | l implementing bowel and                                  |                  |   |                               |
|               | bladder programs to p                              | promote independence, or                                  |                  |   |                               |
|               | developing toileting so                            | chedules to promote                                       |                  |   |                               |
|               |  |   | 1                |   |                               |

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| NAME OF PROVIDER OR SUPPLIER THE COMMONS  STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706   |           | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                 | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |   |
|---|-----------|--|---|-----------------|---|-------------------------------|---|
| NH2407  B. WING   |           |  |   | 7 501251110.    |   |                               |   |
| THE COMMONS  301 SOUTH OAKWOOD ROAD ENID, OK 73706  |           |  | NH2407  | B. WING         |   | 07/01/2021                    |   |
| THE COMMONS ENID, OK 73706  | NAME OF P | PROVIDER OR SUPPLIER   | STREET ADD  | RESS, CITY, STA | TE, ZIP CODE  |                               |   |
| ENID, OK 73706  | THE COM   | IMONS  | 301 SOUTH   | OAKWOOD F       | ROAD  |                               |   |
|   | THE CON   |  | ENID, OK  | 73706           |   |                               |   |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM   | PREFIX    | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL  | PREFIX          | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE COMPLETE                   | Έ |
| LL816 Continued From page 180 continence. (L.) Performing catheter care with proper positioning of bag and tubing at all times. (M) Recording accurate intake and output records for residents with tube feedings or catheters. (N) Assessing the general mental and physical condition of the resident on admission. (O) Updating the assessment and individual care plan when there is a significant change in the resident's physical, mental, or psychosocial functioning. (P) Recognizing and recording signs and symptoms of illness or injury, and the response to treat the illness or injury, and the response to treatments and medications. (2) Personal care shall include, but not be limited to: (A) Keeping residents clean and free of odor. (B) Keeping that residents are dressed appropriately for activities in which they participate; bedfast/chairfast residents shall be appropriately dressed and provided adequate cover for comfort and privacy. (E) Ensuring that the resident's hair is clean and groomed. (F) Providing oral hygiene assistance at least twice daily with readily available dental floss, toothbrush and dentifice. A denture cleaning/soaking device and brush shall be available and maintained for each resident as needed. (G) Keeping too and fingernails clean and trimmed. | LL816     | continence.  (L) Performing cather positioning of bag and (M) Recording accurrecords for residents catheters.  (N) Assessing the good condition of the reside (O) Updating the assecare plan when there the resident's physical functioning.  (P) Recognizing and symptoms of illness of treat the illness or injute treatments and medic (2) Personal care shates:  (A) Keeping resident (B) Keeping bed lines (C) Keeping resident and neat.  (D) Ensuring that reappropriately for active participate; bedfast/of appropriately dressed cover for comfort and (E) Ensuring that the groomed.  (F) Providing oral hy twice daily with readily toothbrush and dentificationing/soaking deviavailable and maintaineeded.  (G) Keeping toenails | eter care with proper d tubing at all times. The rate intake and output with tube feedings or eneral mental and physical ent on admission. Seessment and individual is a significant change in all, mental, or psychosocial decording signs and or injury with action taken to carry, and the response to eations. The response to eations all include, but not be limited to the clean and free of odor. The sens clean and dry. The personal clothing clean ensidents are dressed entities in which they mairfast residents shall be and provided adequate privacy. The resident's hair is clean and regiene assistance at least y available dental floss, rice. A denture ice and brush shall be need for each resident as | LL816           |   |                               |   |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C A. BUILDING: | ONSTRUCTION   | (X3) DATE                         | E SURVEY<br>PLETED       |
|---|---|---|------------------------------|---|-----------------------------------|--------------------------|
|   |   | NU 0 407  | B. WING                      |   |                                   | C                        |
|   |   | NH2407  | B. Wiito                     |   | 01                                | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE          |   |                                   |                          |
| THE COM   | MONS  | ENID, O   | ITH OAKWOOD RO<br>K 73706    | JAU   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO DEFICIENCE) | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL816   | Continued From page   | e 181   | LL816                        |   |                                   |                          |
|   | determined the facility orders were followed sampled residents rephysician's orders.  The facility identified facility.  Findings:  Resident #3 had diag fractured left humerus | ew and staff interview, it was y failed to ensure physician's for one (#3) of three viewed for following  95 residents resided in the |                              |   |                                   |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 182 of 227

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | CONSTRUCTION         |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|----------------------|--|-------------------------------|--------------------------|
| 7.11.2 1 27.11  | or dorate of the transfer of t | IDENTIFICATION NOMBER.  | A. BUILDING:         |  |                               |                          |
|   |  | NH2407  | B. WING              |  |                               | C<br><b>/01/2021</b>     |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STAT    | E, ZIP CODE  |                               |                          |
| THE COM   | MONS   | 301 SOUT<br>ENID, OK  | H OAKWOOD R<br>73706 | OAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLETE<br>DATE |
| LL816   | 02/05/21, documenteFollow up with: [phyWithin 1-2 days"  A progress note, date documented the resid with no new orders.  A progress note, date documented a virtual physician had been ovisit since the emerge On 06/30/21 at 1:50 pwas shown the emerge report and the progre She was asked if phy  | d, "Shoulder pain-swelling visician name deleted]  ed 02/05/21 at 9:54 p.m., dent returned to the facility  ed 02/12/21 at 9:14 a.m., visit with the resident's onducted. This was the first ency department visit.  o.m., the director of nursing gency department final ss note of the virtual visit. visician's orders had been virup appointment. She | LL816                |  |                               |                          |
|   | determined the facility orders were followed sampled residents rephysician's orders.  The facility identified facility.  Findings:  Resident #3 had diag fractured left humerus.  On emergency depart 02/05/21, documente  | viewed for following  95 residents resided in the  noses which included   |                      |  |                               |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 183 of 227

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                          | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |             |  |
|---|--|--|--------------------------|---|-------------|--|
|   |  |  |                          |   | С           |  |
|   |  | NH2407   | B. WING                  |   | 07/01/2021  |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STAT       | TE, ZIP CODE  |             |  |
| THE COM   | MONS   | 301 SOU<br>ENID, OI  | ITH OAKWOOD R<br>K 73706 | OAD   |             |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE |  |
| LL816   |  | d 02/05/21 at 9:54 p.m.,   | LL816                    |   |             |  |
|   | with no new orders.  A progress note, date documented a virtual physician had been or visit since the emerge.  On 06/30/21 at 1:50 p was shown the emerge report and the progres. She was asked if physfollowed for the follow stated, "No, not specifically as the content of the c | o.m., the director of nursing<br>gency department final<br>ss note of the virtual visit.<br>sician's orders had been<br>y-up appointment. She<br>fically." |                          |   |             |  |
| LL902   | State Board of Exami<br>Administrators and ha<br>responsibility for the to<br>subject only to the po-<br>governing authority.<br>(b) The facility shall do<br>the administrator during<br>designated person shall  | shall be licensed by the<br>ners for Nursing Home<br>as the authority and<br>otal operation of the facility,   | LL902                    |   |             |  |
|   | This Rule is not met at On 06/28/21, an Immediate of the situation was determined to have an effect implement an abuse process.  | ediate Jeopardy (IJ) ned to exist related to facility ctive administration to  |                          |   |             |  |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 184 of 227

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|--|---------------------|---|-------------------------------|--------------------------|
|  |   |  | _                   |   |                               | ;                        |
|  |   | NH2407   | B. WING             |   | 1                             | 1/2021                   |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |                               |                          |
| THE COM  | MONS  |  | OAKWOOD F           | ROAD  |                               |                          |
|  | CLIMMADY CT   | ENID, OK   |                     | DROWNERIC DLAN OF CORRECTION  | \ <u>\</u>                    |                          |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL902  | Continued From page   | e 184  | LL902               |   |                               |                          |
|  | and neglect;  ~ protecting residents abuse and neglect;  ~ ensure residents we neglect; and   | ting allegations of abuse during investigations of ere free from abuse and legations without fear of   |                     |   |                               |                          |
|  | A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse. |  |                     |   |                               |                          |
|  | An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work.  |  |                     |   |                               |                          |
|  | being physically abus<br>reported by staff. The<br>resident, complete a t   | ted an incident of resident #5 sed by staff witnessed and se facility failed to protect the thorough investigation and measures to prevent further |                     |   |                               |                          |
|  |   |  |                     |   |                               |                          |
|  | an employee and rep<br>not reported to the ad   | al abuse to Resident #6, by orted it. The allegation was liministrator timely and a n was not conducted. The otected due to the                    |                     |   |                               |                          |

Oklahoma State Department of Health

STATE FORM 6899 If continuation sheet 185 of 227 C7JI11

Oklahoma State Department of Health

|                          | FOF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |  |                                 | E SURVEY<br>PLETED       |
|--------------------------|--|--|----------------------------------|--|---------------------------------|--------------------------|
|                          |  |  |                                  |  |                                 | С                        |
|                          |  | NH2407   | B. WING                          |  | 07                              | 7/01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET   | DDRESS, CITY, STATE              | , ZIP CODE   |                                 |                          |
| THE COM                  | MONS   |  | ITH OAKWOOD RO                   | AD   |                                 |                          |
|                          | OLIMA BY OT  | · · · · · · · · · · · · · · · · · · ·  | K 73706                          | DDOL/IDEDIO DI ANI OF  | OODDECTION                      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902                    | Continued From page  | e 185  | LL902                            |  |                                 |                          |
|                          | perpetrator remaining<br>work while the investi  | at work and continued to gation was on going.  |                                  |  |                                 |                          |
|                          |  | ahoma State Department of notified and verified the uation.  |                                  |  |                                 |                          |
|                          | At 3:30 p.m., the Adm<br>notified of the IJ.   | ninistrator (ADM) was  |                                  |  |                                 |                          |
|                          |  | ded plan of removal was<br>nistrator on 06/29/21 at 7:20<br>he following:  |                                  |  |                                 |                          |
|                          | the INCIDENT RESP and includes the Adm Administrator, DON, A Center Resident serv administrator or design of Director any allegas cheduled monthly m INCIDENT response an outside source on including screening, protection 06/30/2021 with a To always protect our response team will m | ADON, and HealthCare ices Director. The gnee will report to the Board tion of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ng, and reporting/response dvanced training on ABUSE. Tresidents, the INCIDENT eet to collaborate and is to ensure a thorough |                                  |  |                                 |                          |
|                          | On 07/01/21, the adn interviewed and were components of abuse  | able to state the seven  |                                  |  |                                 |                          |
|                          | of 06/30/21 at 5:10 p. plan of removal and t   | rdy deficiency was lifted as<br>m. when all elements of the<br>he amended plan of removal<br>ed. The deficient practice  |                                  |  |                                 |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 186 of 227

|                          | FOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO     |   |                                   | E SURVEY<br>PLETED       |
|--------------------------|---|--|----------------------|---|-----------------------------------|--------------------------|
|                          |   | NH2407   | B. WING              |   | 07                                | C<br>7/ <b>01/2021</b>   |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET /   | ADDRESS, CITY, STATE | , ZIP CODE  | ·                                 |                          |
| THE COM                  | MONS  |  | JTH OAKWOOD RO       | AD  |                                   |                          |
|                          |   | ENID, O  | K 73706              |   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)            | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902                    | Continued From page   | e 186  | LL902                |   |                                   |                          |
|                          | remained at a level o   | f actual harm at a pattern.  |                      |   |                                   |                          |
|                          | interview it was deter  | n, record review and staff<br>mined the facility failed to<br>ninistration to implement an |                      |   |                                   |                          |
|                          | ~ thoroughly investigated and neglect;  | ating allegations of abuse   |                      |   |                                   |                          |
|                          | ~protecting residents abuse and neglect;  | during investigations of   |                      |   |                                   |                          |
|                          |   | were free from abuse for six<br>) of six sampled residents<br>and                          |                      |   |                                   |                          |
|                          |   | nent were staff could report<br>negelect without fear of                                   |                      |   |                                   |                          |
|                          | The facility Censeus  | was  |                      |   |                                   |                          |
|                          | Findings:   |  |                      |   |                                   |                          |
|                          | Resident #9 had chronic pain and oste   | diagnoses which included coarthritis.  |                      |   |                                   |                          |
|                          | A resident assessme documented the resident moderately impaired.  | dent's cognition was   |                      |   |                                   |                          |
|                          | "Resident is at risk<br>muscle spasms and of<br>syndromeResident<br>treated/relieved in a t<br>medications as preso | will have pain<br>imely mannerAdminister<br>ribed"   |                      |   |                                   |                          |
|                          | Physician's orders, da  | ated 06/08/21, documented,   |                      |   |                                   |                          |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 187 of 227

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|               | T OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:        | ` ′                | CONSTRUCTION  | (X3) DATE S<br>COMPL |                  |
|---------------|------------------------------------|---|--------------------|---|----------------------|------------------|
| AND FLAN      | OF CORRECTION                      | IDENTIFICATION NOWIBER.                                   | A. BUILDING:       |   | COWIFE               | ETED             |
|               |                                    |   |                    |   |                      |                  |
|               |                                    | NH2407  | B. WING            |   | 07/0                 | 1/2021           |
| NAME OF P     | ROVIDER OR SUPPLIER                | STREET AI   | DDRESS, CITY, STAT | E, ZIP CODE   |                      |                  |
|               |                                    | 301 SOU   | TH OAKWOOD R       | OAD   |                      |                  |
| THE COM       | MONS                               | ENID, OK  | 73706              |   |                      |                  |
| (X4) ID       | SUMMARY ST                         | ATEMENT OF DEFICIENCIES                                   | ID                 | PROVIDER'S PLAN OF CORRE  | CTION                | (X5)             |
| PREFIX<br>TAG |                                    | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG      | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) |                      | COMPLETE<br>DATE |
| LL902         | Continued From page                | e 187   | LL902              |   |                      |                  |
|               | "hydrocodone 7.5 mg                | [milligrams]-acetaminophen                                |                    |   |                      |                  |
|               |                                    | ) give 1 tablet by oral route                             |                    |   |                      |                  |
|               |                                    | ded FOR CHRONIC PAIN                                      |                    |   |                      |                  |
|               |                                    |   |                    |   |                      |                  |
|               | Tylenol 325 mg capsu               | ule give 2 tablets by oral                                |                    |   |                      |                  |
|               | route every 6 hours a              | s needed for pain   |                    |   |                      |                  |
|               |                                    |   |                    |   |                      |                  |
|               |                                    | give 1 tablet (50 mg) by oral                             |                    |   |                      |                  |
|               | route every 6 hours a              | s needed for pain"  |                    |   |                      |                  |
|               | A statement from CM                | A #3, dated 06/26/21 at                                   |                    |   |                      |                  |
|               |                                    | ted, "Generally every day,                                |                    |   |                      |                  |
|               |                                    | s, typically beginning first                              |                    |   |                      |                  |
|               | thing in the morning a             | after the CNA has helped                                  |                    |   |                      |                  |
|               |                                    | out of bed for the day, he will                           |                    |   |                      |                  |
|               |                                    | will specifically ask for a                               |                    |   |                      |                  |
|               | -                                  | in at an 8 out of 10 for leg or                           |                    |   |                      |                  |
|               |                                    | I, as the CMA, I report the                               |                    |   |                      |                  |
|               |                                    | nurse, the charge nurse will evaluate the resident and    |                    |   |                      |                  |
|               | -                                  | e CMA, with guidance to                                   |                    |   |                      |                  |
|               |                                    | d and instruct me with the                                |                    |   |                      |                  |
|               | level of the pain that             |   |                    |   |                      |                  |
|               | •                                  | n. On many occurrences,                                   |                    |   |                      |                  |
|               |                                    | e resident, [Resident's                                   |                    |   |                      |                  |
|               |                                    | iting 'He just got up, he                                 |                    |   |                      |                  |
|               | 1                                  | vill' or 'He's going outside to                           |                    |   |                      |                  |
|               |                                    | s's not hurting bad enough if                             |                    |   |                      |                  |
|               |                                    | smoke' or 'He can't have a<br>nasn't eaten anything yet.' |                    |   |                      |                  |
|               | 1 -                                | , [Resident] won't receive                                |                    |   |                      |                  |
|               |                                    | times 10 a.m or as late a 2                               |                    |   |                      |                  |
|               | p.m. as reflected on t             |   |                    |   |                      |                  |
|               | administration record              | •   |                    |   |                      |                  |
|               | An OSDH incident for               | rm dated 06/26/21   |                    |   |                      |                  |
|               | An OSDH incident for               | ident #9]Allegations of                                   |                    |   |                      |                  |
|               | Abuse/Mistreatment                 |   |                    |   |                      |                  |
|               |                                    | ed Nurse not approving PRN                                |                    |   |                      |                  |
|               | pain meds when resid               |   |                    |   |                      |                  |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|               | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                  | CONSTRUCTION   | (X3) DATE S |                  |
|---------------|---|--|----------------------|--|-------------|------------------|
| ANDILAN       | O CONNECTION  | IDENTIFICATION NOWIDER.  | A. BUILDING:         |  | COIVII LI   | LILD             |
|               |   | NU 10 40 7   | B. WING              |  | C           |                  |
|               |   | NH2407   |                      |  | 07/0        | 1/2021           |
| NAME OF PI    | ROVIDER OR SUPPLIER   |  | RESS, CITY, STA      |  |             |                  |
| THE COM       | MONS  | ENID, OK   | I OAKWOOD F<br>73706 | ROAD   |             |                  |
| (X4) ID       | SUMMARY ST  | ATEMENT OF DEFICIENCIES  | ID                   | PROVIDER'S PLAN OF CORRECTION  | N           | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG        | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE          | COMPLETE<br>DATE |
| LL902         | Continued From page   | <del>:</del> 188   | LL902                |  |             |                  |
|               | Resident is cognitive called"   | and needs no family  |                      |  |             |                  |
|               | 12:23 [did not docume<br>documented, "Someti<br>pills when it is not tim<br>is scheduled [every] &<br>offered Tylenol if Nord<br>Safe surveys were co | W #3, dated 06/27/21 at ent a.m. or p.m.], mes resident asks for pain e as he had it earlier. Med B [hours] prn. Resident is to can't be given yet"                                      |                      |  |             |                  |
|               | related to receiving pa   | ain medications.   |                      |  |             |                  |
|               | -   | completed on 06/27/21 at   |                      |  |             |                  |
|               | The employee continuinvestigaion of the all   | ued to work during the eged negelct.   |                      |  |             |                  |
|               | The facility did not co investigation and inte include the alleged virmedications being with  | rview residents and staff to ctim regarding pain   |                      |  |             |                  |
|               | assistant administrator conclusion of the investadministrator stated a spreadsheet of which versus the Norco. Sh                                      | p.m., the administrator and or were asked about the estigation. The assistant the had made an excel nurse had given Tylenol the stated the accused nurse medications as much as the      |                      |  |             |                  |
|               | requested the Norco.<br>you could tell when he<br>asked if there was no<br>resident requested it:   | as asked if there was times the resident had She stated she didn't think he had requested it. She was documentation of when the hand the CMA stated LPN #3 hon, how did they come to the |                      |  |             |                  |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C     |  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|--|-------------------------------|
|                          |  |   |                     |  | С                             |
|                          |  | NH2407  | B. WING             |  | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | E, ZIP CODE  |                               |
| THE COM                  | MONS   |   | TH OAKWOOD RO       | DAD  |                               |
|                          | T  | ENID, OF  | 73706               |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE                |
| LL902                    | Continued From page conclusion the allega  | e 189<br>tion was unsubstantiated.  | LL902               |  |                               |
|                          |  | to the resident and asked<br>ted the resident is this<br>leader.  |                     |  |                               |
|                          | There were no questi<br>related to staff withho<br>stated the executive of<br>surveys and thought  | that the question "Do staff   |                     |  |                               |
|                          |  | rr requests and allow you to ding your care" covered  |                     |  |                               |
|                          | if he was in pain. He right side, leg and know rate it at an 8 out of 1 a 9 in the mornings. he did not get his Nor He stated, "If I don't gwas asked if his Nord stated it was and ther | o.m., the resident was asked stated he had pain in his ee. She stated he would 0. He stated it was usually He was asked how he felt if co when he requested it. let them, I get mad." He o was ever withheld. He in stated he would not bloyee was that witheld the |                     |  |                               |
|                          | Norco. She stated, "I the time." She stated because when he ash protocol I have to followould give the same in her statement. She take their pain as the                                 | arding LPN #3 withholding<br>Norco is what he asks for all  |                     |  |                               |
|                          | 2. Resident #7 was a diagnoses which include   | dmitted to the facility with uded convulsions and   |                     |  |                               |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C     |   |           | SURVEY<br>PLETED         |
|--------------------------|--|---|---------------------|---|-----------|--------------------------|
|                          |  |   | A. BUILDING:        |   |           | _                        |
|                          |  | NH2407  | B. WING             |   | 07        | C<br>/ <b>01/2021</b>    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | , ZIP CODE  |           |                          |
| THE COM                  | MONE   | 301 SOU   | TH OAKWOOD RO       | AD  |           |                          |
| THE COM                  | MON5   | ENID, OF  | C 73706             |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| LL902                    | Continued From page  | ÷ 190   | LL902               |   |           |                          |
|                          | anxiety disorder.  |   |                     |   |           |                          |
|                          |  | ssessment, dated 02/18/21,<br>lent's cognition was severely   |                     |   |           |                          |
|                          | documented, "Incid Abuse/Mistreatment IncidentAdministrat allegation of verbal alfrom a staff member a is not on the schedule not be working until the investigated. Investigated and final reports, of the investigationa implemented to prevent attached for investigated. | or was notified today of an ouse occurring on 02/22/21 against a nurse. The nurse of until Thursday. She will ne allegation has been pation is in progressFor 5 please include a summary and corrective measures ent recurrenceSee                  |                     |   |           |                          |
|                          | ways to recognize bu<br>Employee Assistance  | rnout. Also gave her  |                     |   |           |                          |
|                          | _  | se was not reported to the next day after it occurred.  |                     |   |           |                          |
|                          | within two hours to th   | eport the allegation of abuse<br>e appropriate agencies such<br>te Department of Health   |                     |   |           |                          |
|                          | documented, "The da<br>spent a majority of the<br>hallway outside of [ar<br>approximately 2 p.m.<br>himself in his wheelch<br>station area and park<br>outside of the wound  | y CMA #3, dated 02/23/21, y of 2-22-21, [resident #7] e day sitting in the North Hall nother resident]s room. At [resident #7] wheeled nair up closer to the nurse's ed himself in his wheelchair care nurse's office. ge nurse, [LPN #3], stood up |                     |   |           |                          |

Oklahoma State Department of Health

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Oklahoma State Department of Health

| NAME OF PROVIDER OR SUPPLIER  THE COMMONS  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD ENID, OK 73706  | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | 1 ` '   | (X2) MULTIPLE CONSTRUCT  A. BUILDING: | CTION  | (X3) DATE SU<br>COMPLE |          |
|--|---|---|---------------------------------------|--|------------------------|----------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  THE COMMONS  301 SOUTH OAKWOOD ROAD   |   | NH2407  | B. WING                               |  | _                      |          |
| THE COMMONS 301 SOUTH OAKWOOD ROAD   | NAME OF PROVIDER OR SUPPLI  |   | DDRESS, CITY, STATE, ZIP COI          | <br>DE   | 1 0170                 | 1/2021   |
| THE COMMONS  ENID OK 73706   | THE COMMONS   |   |                                       |  |                        |          |
| ENID, OK 13100   | THE COMMONS   | ENID, O   | 73706                                 |  |                        |          |
| (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLET TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | PREFIX (EACH DEF  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   | PREFIX                                | (EACH CORRECTIVE ACTION SHO<br>ROSS-REFERENCED TO THE APPL | OULD BE                | COMPLETE |
| and yelled to [resident #7] "get the hell out of here, you've not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you've not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his roomDuring this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event"  A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurse station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] stat in the Corner til [LPN #3] left he was very upset the rest of the evening"  A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this"  A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from | and yelled to [re here, you're not here." [Resider yelled at [LPN # at her, his spee to health condit again "get the health to me that versident #7] who nurse's station his roomDuring sitting in a chair entire event"  A written statem documented, "Ce #4] came into we sitting at nurses came strolling unurses station [around and go said I dont care and he said he screamed at his your [sic] not sittled with your Acorner til [LPN of the evening  A written statem documented, "Te getting something to gett | elled to [resident #7] "get the hell out of you're not going to sit up here while I'm ' [Resident #7] did raise his hands and at [LPN #3]. I do not know what he yelled his speech is often hard to make out due alth conditions. [LPN #3] then yelled at him "get the hell out of here, you're not going to me that way." After this occurrence, ent #7] wheeled himself away from the 's station area back down the hall towards omDuring this occurrence, [CMA #4] was in a chair beside me and witnessed the event"  Iten statement by CMA #4, dated 02/24/21, mented, "On Monday February 22nd I [CMA ame into work I was on North Hall. I was at nurses station [resident #7] the resident strolling up to the Common Area by the set station [LPN #3] the nurse told him to turn d and go back he said he has rights She dont care Im not gonna [sic] deal with you e said he wanted to sit up here She med at him and said "I dont give a dam [sic] sic] not sitting up here Im not gonna [sic] with your Ass. so [resident #7] sat in the ert til [LPN #3] left he was very upset the rest evening"  Iten statement by CNA #3, dated 02/24/21, mented, "The other day I was in the office g something when I heard [LPN #3] yelling sident #7]. And telling him to go to his room. Ident #7] started yelling back at her and [LPN tot louder and told him she wasn't going to to it. Go to your room. [LPN #3] then said it of him acting like this" | LL902                                 |  |                        |          |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|---------------------|--|-------------------------------|
| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER.   | A. BUILDING:        | A. BUILDING:   |                               |
|                          |  |  |                     |  | С                             |
|                          |  | NH2407   | B. WING             |  | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AL  | DDRESS, CITY, STAT  | E, ZIP CODE  |                               |
|                          |  | 301 SOU  | TH OAKWOOD R        | OAD  |                               |
| THE COM                  | MONS   | ENID, OK   | 73706               |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIV<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE COMPLETE                 |
| LL902                    | Continued From page  | e 192  | LL902               |  |                               |
|                          | [administrator (admin back [and] was told the against me for yelling Monday February 22r [approximately] [2:00 the man but supposed [admin] via the camer told I told male reside hall or go to his room to sit in the area by wit congests the hallwastowards the resident  A investigative summ "Who is/are the reputation #7]Who is/are the reputa | p) [at] the Commons. Called here was an allegation [at] a male on North Hall on and [at] approx p.m.]Not only did I yell [at] dly I cussed [at] him also per ras. No AudioWas also ant to go away, go down the I had asked residents not ound care Nurse's office as anyMay of raised my voice in any, undated, documented, orted victim[resident reported perpetrator[LPN the incident[CMA #3], what in his wheelchair is desk. [LPN #3] the nurse and started yelling at him to at is the history of the incident foreseeableThe preaks lately, but there is NO er should yell at a resident. In a resident when asked what he he just shrugged his he incident happenAround by 22ndWhen was facility ment staff first contacted |                     |  |                               |
|                          | submitted date 02/26,<br>Name: [LPN #3]Did<br>or Criminal Behavior.  | of Nursing complaint form,<br>/21, documented, "Nurse's<br>incident include Misconduct<br>Yes: Patient<br>f InvestigationLPN was   |                     |  |                               |

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|                                      | CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING: _    |   |             |
|--------------------------------------|--|---|-------------------|---|-------------|
|                                      |  |   |                   |   |             |
|                                      |  |   |                   |   | С           |
|                                      |  | NH2407  | B. WING           |   | 07/01/2021  |
| NAME OF PRO                          | OVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, STA | TE, ZIP CODE  |             |
|                                      |  |   | TH OAKWOOD F      |   |             |
| THE COMM                             | ONS  | ENID, OK  |                   |   |             |
| (X4) ID                              | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID                | PROVIDER'S PLAN OF CORRECTIO  | N (X5)      |
| PREFIX<br>TAG                        | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE |
| LL902                                | Continued From page  | 193   | LL902             |   |             |
| ;<br>;<br>;<br>;<br>;<br>;<br>;<br>; | suspended pending the returned to work on 02 disciplinary action write a resident and for concontrary to recognized employment at the factor of the sheet for pay pour pour of the facility failed to proper abuse during the investment of the administrator and not completed. | ne investigation and 2/26/2021. She received the up for raising her voice at ducting herself in a manner of standards. Her cility is being retained"  The riod from 02/14/21 to the did LPN #3 worked til 6:48 to worked approximately the safter the abuse occurred. |                   |   |             |
| 1 (                                  | to describe the incider<br>02/22/21 with resident<br>resident is hard of hea   | nt that happened on<br>t #7. She stated the<br>aring and LPN #3 stated she  |                   |   |             |
| 1 4                                  | took statements from<br>and discussed the inc<br>wife. She was asked   | I she reviewed the cameras,<br>the witnesses and LPN #3<br>ident with the resident's<br>when LPN #3 worked on<br>she didn't know. She was   |                   |   |             |
| ;<br>\                               | stated she was notifie<br>was asked what the o   | ent was reported. She d on the following day. She utcome of her investigation is substantiated that LPN #3  |                   |   |             |
| 1 1 2                                | write up. She was asl tolerance for abuse. Shand book is wrong." done to protect and protect of the country to other residents. Shanything else other the  | was suspended and had a ked if the facility had a zero She stated, "If I say yes, my She was asked what was revent this from happening he stated they didn't add an what was in place. She aff can report suspected   |                   |   |             |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE C     |  |                                   | SURVEY<br>PLETED         |
|--------------------------|--|--|---------------------|--|-----------------------------------|--------------------------|
|                          |  |  | A. BUILDING:        | <del></del>  |                                   |                          |
|                          |  | NH2407   | B. WING             |  | 07                                | C<br>// <b>01/2021</b>   |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AD  | DDRESS, CITY, STATE | . ZIP CODE   | •                                 |                          |
|                          |  |  | TH OAKWOOD RO       |  |                                   |                          |
| THE COM                  | MONS   | ENID, OK   | 73706               |  |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
|                          | asked when the staff did they report timely asked if the staff who in serviced about report in serviced about report in serviced about report in serviced about report in serviced about abuse happeners. She stated "Yes continued to work after was asked if LPN #3 residents, how were the stated," They couldn't about it." She was as report the abuse imming protected. She stated | if the resident was assessed   |                     |  |                                   |                          |
|                          | not immediately report worked with the victin approximately four hore.  The facility did not purplace to prevent abust result, one of the with allegation of verbally. The facility substantiaterminated CMA #4 we employed by the facil.  3. Resident #5 was and diagnoses which included.  | t any corrective measures in see from reoccurring. As a sesses [CMA #4] had an abusing a different resident. ated allegation and while LPN #3 continued to be ity.  dmitted to the facility with added dementia.  ssessment, dated 05/02/21, |                     |  |                                   |                          |
|                          | documented the resid   | lent's cognitive skills for was severely impaired.   |                     |  |                                   |                          |

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|               | OF DEFICIENCIES         | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE    | CONSTRUCTION                                    | (X3) DATE |                  |
|---------------|-------------------------|--|------------------|---|-----------|------------------|
| AND PLAN      | OF CORRECTION           | IDENTIFICATION NUMBER:                                     | A. BUILDING:     |   | COMP      | PLETED           |
|               |                         |  |                  |   |           | С                |
|               |                         | NH2407   | B. WING          |   | 07        | /01/2021         |
| NAME OF P     | ROVIDER OR SUPPLIER     | STREET AD  | DRESS, CITY, STA | TE, ZIP CODE                                    |           |                  |
| TUE 00M       | MONO                    | 301 SOUT   | H OAKWOOD F      | ROAD  |           |                  |
| THE COM       | MONS                    | ENID, OK   | 73706            |   |           |                  |
| (X4) ID       | SUMMARY ST              | ATEMENT OF DEFICIENCIES                                    | ID               | PROVIDER'S PLAN OF CO                           | ORRECTION | (X5)             |
| PRÉFIX<br>TAG | ,                       | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE |           | COMPLETE<br>DATE |
|               |                         |  |                  | DEFICIENCY)                                     |           |                  |
| LL902         | Continued From page     | e 195  | LL902            |   |           |                  |
|               |                         |  |                  |   |           |                  |
|               | An initial incident rep | ort form, dated 06/07/21,                                  |                  |   |           |                  |
|               | -                       | dentInvolved[resident                                      |                  |   |           |                  |
|               | #5]Incident Type        |  |                  |   |           |                  |
|               | Abuse/Mistreatment      | •  |                  |   |           |                  |
|               | IncidentReceived a      |  |                  |   |           |                  |
|               | towards a resident by   |  |                  |   |           |                  |
|               |                         | pending investigation"                                     |                  |   |           |                  |
|               |                         |  |                  |   |           |                  |
|               | A written statement fr  | rom CMA #2, dated  |                  |   |           |                  |
|               |                         | d "Around [8:30 a.m.] [CNA                                 |                  |   |           |                  |
|               | #2] asked me if I coul  | ld come help her I told her                                |                  |   |           |                  |
|               | yes just give me a se   | cond because I was in the                                  |                  |   |           |                  |
|               | middle of taking care   | of another Resident. When                                  |                  |   |           |                  |
|               | I walked into [residen  | t #5]'s room [CNA #2] had                                  |                  |   |           |                  |
|               | ahold [sic] of his Righ | it arm yanking [and] pulling                               |                  |   |           |                  |
|               | on him while she was    | s slapping at his left leg,-on                             |                  |   |           |                  |
|               |                         | t her to stop doing him that                               |                  |   |           |                  |
|               |                         | e what [and] just kind of                                  |                  |   |           |                  |
|               |                         | the bed, she went to pull on                               |                  |   |           |                  |
|               |                         | I told her to just leave that I                            |                  |   |           |                  |
|               |                         | m. I brought him out for                                   |                  |   |           |                  |
|               |                         | ne Charge Nursewhat had                                    |                  |   |           |                  |
|               |                         | n [LPN #2] talked to [CNA                                  |                  |   |           |                  |
|               | l                       | ay away from direct care of                                |                  |   |           |                  |
|               | -                       | I seen [sic] D.O.Naround                                   |                  |   |           |                  |
|               |                         | f [LPN #2] had talk to her                                 |                  |   |           |                  |
|               |                         | at had happened She told                                   |                  |   |           |                  |
|               | asked me to write ou    | re but now she is [and]                                    |                  |   |           |                  |
|               | asked file to write ou  | i a statement  |                  |   |           |                  |
|               | A written statement fr  | om LPN #2, dated 06/07/21,                                 |                  |   |           |                  |
|               |                         | #2] came to me and stated "I                               |                  |   |           |                  |
|               |                         | cause she came out to ask                                  |                  |   |           |                  |
|               |                         | esident #5] up I went into the                             |                  |   |           |                  |
|               |                         | and he was mad and hitting                                 |                  |   |           |                  |
|               |                         | her grab his arm and swat                                  |                  |   |           |                  |
|               |                         | her to leave and I would                                   |                  |   |           |                  |
|               |                         | CNA #2] and asked what                                     |                  |   |           |                  |
|               | _                       | was just playing and I would                               |                  |   |           |                  |

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| AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING:  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706   | ON          |                          |
|--|-------------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706  | <b>07/0</b> |                          |
| THE COMMONS  301 SOUTH OAKWOOD ROAD ENID, OK 73706   | ON          |                          |
| THE COMMONS ENID, OK 73706   |             |                          |
| ENID, OK 73706   |             |                          |
|  |             |                          |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY)  | PRIATE      | (X5)<br>COMPLETE<br>DATE |
| LL902 Continued From page 196 LL902  |             |                          |
| never hurt anyone was told by nurse to stay out of room"   |             |                          |
| A written statement from CNA #2, dated 06/07/21, documented, "[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while I have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting hisleg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurseask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise"  An investigative summary, undated, documented, "Who isreported perpetrator[CNA #2]What happenedAllegation that CNA was yanking on Residents arm and slapping his legWhat was done to protect the resident(s) from further harmStaff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigativo yof the residentWas |             |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 197 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE C   | ONSTRUCTION         |  | E SURVEY<br>PLETED             |                        |
|--|---|---|---------------------|--|--------------------------------|------------------------|
|  |   | NH2407  | B. WING             |  | 07                             | C<br>7/ <b>01/2021</b> |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE | , ZIP CODE   |                                |                        |
| THE COM  | MONS  | 301 SOU<br>ENID, OI   | TH OAKWOOD RO       | AD   |                                |                        |
| (X4) ID  | SLIMMARY S  | TATEMENT OF DEFICIENCIES  | ID                  | PROVIDER'S PLAN OF (   | CORRECTION                     | (X5)                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG       | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | COMPLETE<br>DATE       |
| LL902  | the incident foreseed of being combative the deliveredWhen did happen06/07/21, [supervisory/manage about the incident[  A final state report, on the incident[  C.M.A skin sweep was by two nurses with nurses allow on the incident and residents.  A final state report, on the incident[  C.M.A skin sweep was by two nurses with nurses allow on the incident and residents.  The facility had documunus beta to investigation by interest and residents. | ableResident has a history or staff when cares are at the incident 7:30 a.m.]When was facility ement staff first contacted 10:00 a.m.]"  dated 06/08/21, documented, a completed on the resident ror injuries notedThe rewas suspended on an investigation. On counseled by the DON and the received verbal education insidered to be abuse. She elias Training entitled entia. The accused wed to return to work on 11:37 and from 10:36 a.m. to 11:37 and from 8:27 a.m. to 1:27 p.m., to 2:32 p.m.  Immented the allegation was an through there was a complete a thorough reviewing other staff members | LL902               |  |                                |                        |
|  | to describe her inves<br>she would complete<br>and suspend staff, to<br>staff on the hall that<br>complete safe surve<br>the section of the ha  | 8 p.m., the DON was asked stigation process. She stated an incident report, remove ake statements from other the incident occurred and ys on cognitive residents on all the incident occurred. She orked the same hall. She   |                     |  |                                |                        |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  |                     | (X3) DATE SURVEY<br>COMPLETED  |                 |
|---|---|--|---------------------|--|-----------------|
|   |   |  | A. BUILDING: _      |  |                 |
|   |   | NH2407   | B. WING             |  | C<br>07/01/2021 |
|   |   | 14112-407  |                     |  | 07/01/2021      |
| NAME OF P   | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STAT  |  |                 |
| THE COM   | MONS  |  | TH OAKWOOD R        | ROAD   |                 |
|   | I   | ENID, OK   | 73706               |  |                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE   |
| LL902   | Continued From page   | 198  | LL902               |  |                 |
| LL902   | stated not always. Siconsidered interviewing on other halls. She is other staff but not oth asked when the investigation stated on 06/07/21 at when the investigation stated late on 06/07/2 thorough investigation stated, "I feel it was the resident was assed delayed injury. She is she was asked when 06/07/21. She stated lunch and when she in suspended and sent I she worked on 06/08/here at 8:30 a.m. to in Relias training then re | ne was asked if she ng other staff and residents tated she has interviewed er residents. She was stigation was started. She 10:00 a.m. She was asked in was completed. She 11. She was asked if a n was conducted. She norough." She was asked if essed after incident for tated, "No."  CNA #2 had worked on she left at 10:04 a.m. for | LL902               |  |                 |
|   | about dementia, she and two and a half howas asked what correplace to prevent furth residents. She stated The DON stated she happened because C and she called the CN   | •  |                     |  |                 |
|   | LPN #2 did not report<br>immediately and as a<br>work with other reside<br>and a half to two and<br>investigation was not   | incident to the DON result, CNA #2 continued to ents for approximately one a half hours. A thorough completed by not ff and residents. As a result,  |                     |  |                 |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 199 of 227

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ' ·  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED  |                          |
|---|--|--|--|--|--------------------------------|--------------------------|
| NH2407  |  | B. WING  |  | 07   | C<br>7/ <b>01/2021</b>         |                          |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATE                      | , ZIP CODE   | ·                              |                          |
| THE COM   | MONS   | 301 SOL  | TH OAKWOOD RO                            | AD   |                                |                          |
| THE COM   | WIONS  | ENID, O  | K 73706                                  |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902   | Continued From page  | e 199  | LL902                                    |  |                                |                          |
|   | involved.  |  |  |  |                                |                          |
|   |  | iagnoses which included<br>sacrum requiring a wound<br>in.   |  |  |                                |                          |
|   | A time record for RN documented she worl a.m.  | #2, dated 06/27/21,<br>ked from 5:33 p.m. to 5:39  |  |  |                                |                          |
|   | A time record for CNA documented she worl a.m.   | A #5, dated 06/27/21,<br>ked from 10:01 p.m. to 5:39   |  |  |                                |                          |
|   | documented, "She she was raped by 50 minutesStaff is not                                 |  |  |  |                                |                          |
|   | observed to be at the<br>When approached, th<br>a call that a resident h                 | a.m., two police officers were front door to the facility. They stated they had received they been sexually abused. They had received the out five minutes ago." |  |  |                                |                          |
|   | talk to you guys." Sh  | ninistrator stated, "I need to<br>e stated, "We have a crazy<br>as raped and I didn't send   |  |  |                                |                          |
|   | documented, "Final<br>of Abuse/Mistreatmer<br>IncidentResident m<br>being raped by 50 pe | akes allegation that she was ople every 30 minutes. She vere trying to poison her  |  |  |                                |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 200 of 227

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED   |               |
|---|---|---|-------------------|---|---------------|
| NH2407 B.   |   | B. WING   |                   | C<br>07/01/2021   |               |
| NAME OF D   | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STA | TE ZIR CODE   | 1 0.70 2021   |
| NAIVIE OF F   | ROVIDER OR SUPPLIER   |   | TH OAKWOOD F      |   |               |
| THE COM   | MONS  | ENID, OK  |                   | (OAD  |               |
| (X4) ID   | SUMMARY STA   | ATEMENT OF DEFICIENCIES   | ID                | PROVIDER'S PLAN OF CORRECTION   | DN (X5)       |
| PREFIX<br>TAG   | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE |
| LL902   | Continued From page   | 200   | LL902             |   |               |
|   | day and final reports, of the investigation\$  A report summary, da     |   |                   |   |               |
|   | "Who is/are the repo<br>woman and 50 of theil<br>happenedAccusation     | orted perpetrator(s)A<br>mWhat  |                   |   |               |
|   | from further harmSt<br>room 2 at a timeWh<br>of the incidentNotific     | aff was to always go in<br>at was done upon discovery<br>ed AdministratorWhat is  |                   |   |               |
|   |   | done at 5PM<br>facility<br>ent staff first contacted  |                   |   |               |
|   |   | #2 documented,<br>o.m. to 11:15 p.m.] Resident  |                   |   |               |
|   | The bed was checked sign of bugs. She that she was raped. She           | re was bed bugs in her bed.<br>I by 2 staff and found no<br>In [sic] began saying that<br>has been yelling these                    |                   |   |               |
|   | woman and there is 5<br>She cannot really des<br>going in her room with | that the rapest [sic] is a 0 of them every 5 minutes. cribe themStaff has been 1 2 people and then after tration we have been going |                   |   |               |
|   | A statement from CNA  | A #5, dated 06/28/21 at<br>ted, "At 11:14 pm [Resident  |                   |   |               |
|   | #8] started yellingSI<br>yelling rape. She said<br>everyone has been ra | nortly after she started d she was raped and that uped. She said that she has minutes by 50 people"                                 |                   |   |               |
|   | A statement, dated 06   | 6/28/21, from CNA #7,   |                   |   |               |

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STATE FORM 6899 C7JI11 If continuation sheet 201 of 227

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:   |                      | E SURVEY<br>PLETED   |                                |                          |
|---|---|---|----------------------|--|--------------------------------|--------------------------|
|   |   |   | 7. 201251110.        |  |                                | С                        |
|   |   | NH2407  | B. WING              |  | 07                             | //01/2021                |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A  | ADDRESS, CITY, STATE | . ZIP CODE   | ·                              |                          |
|   |   |   | JTH OAKWOOD RO       |  |                                |                          |
| THE COM   | MONS  | ENID, O   | K 73706              |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902   | Continued From page   | e 201   | LL902                |  |                                |                          |
|   | documented, "Reside abused and raped re   | ent stated she was being<br>peatedly"   |                      |  |                                |                          |
|   | documented, "On 6 [resident #8's room n   | 6/28/21, from CMA #5<br>6-28-2021, resident in RM<br>umber] has been yelling<br>and saying the police are   |                      |  |                                |                          |
|   | had received a text m<br>nurse last night at 11<br>resident's wound vac<br>was observed to be r<br>from the charge nurs<br>when the nurse went<br>resident alleged rape<br>the nurse had inform<br>to go in there alone.<br>told the nurse to go a<br>get a description of w<br>The nurse told the AI<br>female rapist and 50 | a.m., the ADM stated she nessage from the charge :14 p.m. that stated the had alarmed. The ADM eading the text messages e as we spoke. She stated in to check the alarm, the . The administrator stated ed her she had told staff not The administrator stated she lisk when it happened and what the person looked like. DM the resident reported a people every 30 minutes. It is that the rapist |                      |  |                                |                          |
|   | with the resident last<br>She stated she had in<br>the family and physic<br>resident. She stated<br>assessed. The admi<br>nurse, "You can't rap<br>close to." She was a   | how many staff had worked night. She stated, "Two." instructed the nurse to inform ian and to assess the the resident refused to be nistrator stated she told the e someone you can't get sked who the two staff were g with the resident. She and an RN.   |                      |  |                                |                          |
|   | residents once she w  | how she protected the<br>ras made aware of the<br>he stated, "I told her to go in   |                      |  |                                |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 202 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|---------------------|--|-------------------------------|--------------------------|
|   |   |   | A. BOILBING.        |  | c                             |                          |
|   |   | NH2407  | B. WING             |  | 1                             | 1/2021                   |
| NAME OF PROVIDER OR   | SUPPLIER  | STREET A  | DDRESS, CITY, STA   | TE, ZIP CODE   |                               |                          |
| THE COMMONS   |   |   | TH OAKWOOD I        |  |                               |                          |
| THE COMMONS   |   | ENID, OF  | 73706               |  |                               |                          |
|   | CH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| with two, facility powas an al find the poreading it them, sust two staff hat the time She was a she state She was a employee followed.  On 06/29/regarding reviewed her reported the perpetrate investigate unable to "Yes", referinformation concernee "What doe interview reported the "looks like resident when the two efacility all | licy was for legation of a colicy." She stated spend." She stated e." She stated d, "I don't knasked if her as for allegations for allegations as the stated where she is that the AD where she is that the resors as "looks ive report do give a descerning to the ent. She was discount the est the report of her the desire that the resors as "looks ive report do give a descerning to the ent. She was discount the est the report of her the desire and the vas unable to some responsibility and the est the report of her the desire and the vas unable to some responsibility after the destriction of the state of the continuity and the entity ing the destriction of the state of of the | "She was asked what the protecting residents if there abuse. She stated, "Let me located the policy and began d, "Immediately remove was asked if either of the ispended. She stated, "Not ted, "I came and did it later." time she suspended them. now, I was with the police." policy for suspending tions of abuse had been, "No."  a.m., the investigation allegation of rape was M. She stated she based if statements.  DM her interview from reported the charge nurse sident described the selike us" and that the ocumented the resident was cription. The ADM stated, discrepancies in selection asked if she was discrepancies. She stated, the say. "Reviewed her day that she stated the nurse escription the resident stated the report documented the condescribe the perpetrator. | LL902               |  |                               |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 203 of 227

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE       | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|---------------------|---|-------------------------------|--|
| AND PLAN   | OF CORRECTION   | IDENTIFICATION NUMBER.  | A. BUILDING:        |   | COMPLETED                     |  |
|  |   | NH2407  | B. WING             |   | C<br>07/01/2021               |  |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                               |  |
| THE COM  | MONS  |   | OAKWOOD F           | ROAD  |                               |  |
|  |   | ENID, OK  | 73706               |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE                   |  |
| LL902  | Continued From page   | e 203   | LL902               |   |                               |  |
|  | The facility failed to h investigation into the   | ave an accurate a thorough allegations.   |                     |   |                               |  |
|  | 5. Resident #6 had di<br>Huntington's disease.  | agnoses which included  |                     |   |                               |  |
|  | A resident assessmer documented the resident  | nt, dated 02/15/21,<br>dent's cognition was intact.   |                     |   |                               |  |
|  | A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.   |   |                     |   |                               |  |
|  |   | 03/21/21 at 1:44 p.m.,<br>ent observed on floor lying on  |                     |   |                               |  |
|  | documented, "Alleg MistreatmentDescri IncidentAdministrate director that activity a statement, that she or F******* Christ, [Reside notified he had fallen. The nurse is suspend complete" A facsim | ption of or was notified by Activity ide reported to her in a verheard a nurse say "Jesus ent #6] really? when she was Nurse is not on shift today. led until investigation is nile (fax) cover sheet, rt was sent to the OSDH on |                     |   |                               |  |
|  |   | entation in the resident's<br>alleged abuse against the   |                     |   |                               |  |
|  | -   | oort the allegation of abuse<br>e Department of Health<br>o hours.  |                     |   |                               |  |
|  | A time record for LPN worked on 03/23/21 f  | l #1 documented she<br>rom 5:42 a.m. to 2:34 p.m.   |                     |   |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE C<br>A. BUILDING:  |                     | , ,  | SURVEY<br>PLETED             |                          |
|--|--|--|---------------------|--|------------------------------|--------------------------|
|  |  | B. WING  |                     |  | С                            |                          |
|  |  | NH2407   | B. WING             |  | 07                           | //01/2021                |
| NAME OF P  | ROVIDER OR SUPPLIER  | STREET AL  | DDRESS, CITY, STATE | E, ZIP CODE  |                              |                          |
| THE COM  | MONS   |  | TH OAKWOOD RO       | DAD  |                              |                          |
|  | T  | ENID, OK   | 73706               |  |                              |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902  | Continued From page  | 204  | LL902               |  |                              |                          |
|  | at 6:38 p.m., docume   | •  |                     |  |                              |                          |
|  | on 03/23/21. The folloasked: 1. Do you feel like who light, you get everythin 2. Have you heard stall language? 3. Has staff ever yelled 4. If you feel like your know who to talk to? No negative answers   | en you turn on your call ng you need taken care of? aff using inappropriate ad or spoken harsh to you? needs aren't met, do you  |                     |  |                              |                          |
|  | There were no writter reporting staff member or other staff with the administrator docume the staff member make others. She documented reported hearing the commender who had manadministrator docume incident did not occur.  On 06/24/21 at 1:35 pwhen LPN #1 worked she worked til 3:21 p. did the LPN receive. | ented that she had spoken to<br>king the allegation and three<br>nted she spoke with resident<br>the only person who<br>comments was the staff<br>de the allegation. The<br>ented her conclusion was the |                     |  |                              |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 205 of 227

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     | (X3) DATE SURVEY COMPLETED   |             |
|---|--|--|---------------------|--|-------------|
|   |  |  |                     | С  |             |
|   |  | NH2407   | B. WING             | <del></del>  | 07/01/2021  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STA    | TE, ZIP CODE   |             |
| THE COM   | MONS   | 301 SOUT<br>ENID, OK   | TH OAKWOOD I        | ROAD   |             |
| (V4) ID   | SLIMMARY STA   | ATEMENT OF DEFICIENCIES  |                     | PROVIDER'S PLAN OF CORRECTION  | N (X5)      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE |
| LL902   | Continued From page  | 205  | LL902               |  |             |
|   | failed to have an effectimplement an abuse p   | ned to exist related to facility ctive administration to   |                     |  |             |
|   | and neglect;  ~ protecting residents abuse and neglect;  ~ ensure residents we neglect; and        | during investigations of ere free from abuse and egations without fear of  |                     |  |             |
|   | refusing/withholding p<br>#9. The allegation wa<br>administrator and a th<br>not conducted. The el | d that LPN #3 had been that medications to resident as not reported timely to the corough investigation was amployee remained working on and no action was taekn |                     |  |             |
|   | resident #7 on 02/22/2<br>02/23/21, one day after  | peing verbally abusive to 21 was not reported until er the allegation occurred. ot protected as the staff to work.   |                     |  |             |
|   | being physically abus<br>reported by staff. The<br>resident, complete a t                          | ed an incident of resident #5 ed by staff witnessed and e facility failed to protect the horough investigation and measures to prevent further                   |                     |  |             |
|   |  | allegation of rape by staff<br>staff had been allowed to<br>six hours after the  |                     |  |             |

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Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   |                     | (X3) DATE SURVE<br>COMPLETED  | Υ           |                         |
|---|--|---|---------------------|---|-------------|-------------------------|
|   |  |   | A. BUILDING: _      |   |             |                         |
|   |  | NH2407  | B. WING             |   | 07/01/20    | 21                      |
|   |  |   |                     | T. J.D 0005   | 1 017011201 |                         |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STA   | •   |             |                         |
| THE COM   | MONS   | 301 SOU<br>ENID, OF   | TH OAKWOOD F        | ROAD  |             |                         |
| ()(1) ID  | SLIMMARY ST.   | ATEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF CORRECTI   | ON          | (VE)                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE CO     | (X5)<br>DMPLETE<br>DATE |
| LL902   | Continued From page  | e 206   | LL902               |   |             |                         |
|   | Staff witnessed verbal an employee and reported to the additional thorough investigation residents were not properpetrator remaining work while the investional three investio | all abuse to Resident #6, by orted it. The allegation was an initiative timely and a new was not conducted. The otected due to the pat work and continued to gation was on going.  Ahoma State Department of notified and verified the uation.  Aninistrator (ADM) was  ded plan of removal was inistrator on 06/29/21 at 7:20 he following:  E team was formed called ONSE TEAM on June 29th, inistrator, Assistant ADON, and HealthCare inces Director. The gnee will report to the Board tion of abuse at regularly eetings at a minimum. The team will be in-serviced by all aspects of ABUSE - preventing, identifying, ng, and reporting/response dvanced training on ABUSE. residents, the INCIDENT eet to collaborate and is to ensure a thorough |                     |   |             |                         |
|   | On 07/01/21, the adm<br>interviewed and were<br>components of abuse  | able to state the seven   |                     |   |             |                         |

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STATE FORM 6899 C7JI11 If continuation sheet 207 of 227

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|--|---|-------------------------------|--------------------------|
|   |  |   | _  |   | C                             |                          |
|   |  | NH2407  | B. WING                                  |   | 07/01/                        | /2021                    |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA                          | TE, ZIP CODE  |                               |                          |
| THE COM   | MONS   |   | OAKWOOD F                                | ROAD  |                               |                          |
|   |  | ENID, OK  | 1  |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                 | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL902   | Continued From page  | e 207   | LL902                                    |   |                               |                          |
|   | of 06/30/21 at 5:10 p. plan of removal and that been implemented remained at a level of Based on observation interview it was determined at a effective admatuse program for:  ~ thoroughly investigate and neglect;  ~protecting residents abuse and neglect;  ~ensuring residents w (#1, 5, 6, 7, 8 and #9) reviewed for abuse; at a have an environemallegations of abuse/reprisal.  The facility Censeus with the fa | nent were staff could report negelect without fear of was diagnoses which included coarthritis. |  |   |                               |                          |
|   |  | date 01/07/21, documented,  |  |   |                               |                          |
|   | "Resident is at risk muscle spasms and c   |   |  |   |                               |                          |

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STATE FORM 6899 If continuation sheet 208 of 227 C7JI11

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER  | MULTIPLE CONSTRUCTION UILDING:   | (X3) DATE SURVEY<br>COMPLETED |
|---|--|-------------------------------|
| A. 50   | DILDING.   | 0                             |
| NH2407 B. WII   | ring   | C<br><b>07/01/2021</b>        |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. C  | CITY, STATE, ZIP CODE  |                               |
| 301 SOUTH OAK   |  |                               |
| THE COMMONS ENID, OK 73706  |  |                               |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR   | ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               |
| syndromeResident will have pain treated/relieved in a timely mannerAdminister medications as prescribed"  Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN  Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain  Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain"  A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 | DEFICIENCY)  |                               |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CO  |                     |  | E SURVEY<br>PLETED             |                          |
|---|---|---|---------------------|--|--------------------------------|--------------------------|
|   |   | NH2407  | B. WING             |  | 07                             | C<br><b>7/01/2021</b>    |
| NAME OF F   | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, STATE | , ZIP CODE   | ·                              |                          |
| THE COM   | IMONS   | 301 SOU<br>ENID, OK   | TH OAKWOOD RO       | AD   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902   | An OSDH incident for documented, "[Readouse/Mistreatment IncidentStaff reporpain meds when researched is cognitive called"  A statement from LP 12:23 [did not documented, "Some pills when it is not tir is scheduled [every] offered Tylenol if No. Safe surveys were of the questions asked related to receiving proceed to the company of the authorized to the company of the invalidation of the invalidation. She was a support of the invalidation of the invalidation of the invalidation of the invalidation of the invalidation. She was a support of the invalidation of the invalidation of the invalidation of the invalidation of the invalidation. She was a support of the invalidation of the invalidation of the invalidation of the invalidation of the invalidation. She was a support of the invalidation of the | orm, dated 06/26/21, sident #9]Allegations ofDescription of red Nurse not approving PRN sident asked for them. e and needs no family  PN #3, dated 06/27/21 at ment a.m. or p.m.], stimes resident asks for pain me as he had it earlier. Med 8 [hours] prn. Resident is rco can't be given yet"  conducted with five residents. d to the residents were not pain medications.  Inted the allegation was a completed on 06/27/21 at mued to work during the lleged negelct.  In the property of the property of the pain medications at complete a through the leged negelct. | LL902               |  |                                |                          |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|---|-------------------------------|--|
|                          |  |   | 71. 201231110.                           |   | С                             |  |
|                          |  | NH2407  | B. WING                                  |   | 07/01/2021                    |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, STAT                        | TE, ZIP CODE  |                               |  |
|                          |  |   | TH OAKWOOD R                             |   |                               |  |
| THE COM                  | MONS   | ENID, OK  | 73706                                    |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE COMPLETE                 |  |
| LL902                    | you could tell when hasked if there was no resident requested it withheld the medicatic conclusion the allegar. She stated she wenthim about it. She stanurse's biggest cheer.  At 1:19 p.m., the ADN There were no questirelated to staff withhostated the executive surveys and thought members respect you make decisions regarthat.  On 06/29/21 at 6:35 pif he was in pain. He right side, leg and known at a side of 1 a 9 in the mornings. He did not get his Nord stated it was and their disclose who the empredication.  At 7:02 p.m., CMA #3 allegations made regards. | She stated she didn't think e had requested it. She was documentation of when the and the CMA stated LPN #3 on, how did they come to the tion was unsubstantiated. to the resident and asked ted the resident is this leader.  If provided resident surveys one asked to the residents lding pain medications. She director had made the that the question "Do staff or requests and allow you to ding your care" covered  o.m., the resident was asked stated he had pain in his ee. She stated he would  O. He stated it was usually He was asked how he felt if too when he requested it. get them, I get mad." He o was ever withheld. He | LL902                                    | DEFICIENCY)   |                               |  |
|                          | the time." She stated<br>because when he ask<br>protocol I have to followould give the same<br>in her statement. She   |   |  |   |                               |  |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | ` '                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |             |                          |
|--------------------------|---|---|---------------------|--|-------------|--------------------------|
|                          |   |   | A. BOILDING.        |  | С           |                          |
|                          |   | NH2407  | B. WING             |  | 07          | //01/2021                |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE | , ZIP CODE   |             |                          |
| THE COM                  | MONS  | 301 SOU   | TH OAKWOOD RO       | AD   |             |                          |
| 1112 0011                | imono   | ENID, OF  | K 73706             |  |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| LL902                    | Continued From page   | 211   | LL902               |  |             |                          |
|                          | #3 would have her ad instead of the Norco.  | lminister Tylenol or Ultram   |                     |  |             |                          |
|                          | Resident #7 was a diagnoses which incluanxiety disorder.  | dmitted to the facility with uded convulsions and   |                     |  |             |                          |
|                          |   | ssessment, dated 02/18/21,<br>lent's cognition was severely   |                     |  |             |                          |
|                          | documented, "Incid Abuse/Mistreatment IncidentAdministrate allegation of verbal at from a staff member a is not on the schedule not be working until the investigated. Investig day and final reports, of the investigationa implemented to preve attached for investigaresident. She was su ways to recognize bu Employee Assistance  The allegation of abuse administrator until the The facility failed to rewithin two hours to the | or was notified today of an ouse occurring on 02/22/21 against a nurse. The nurse e until Thursday. She will ne allegation has been gation is in progressFor 5 please include a summary and corrective measures ent recurrenceSee tion: Nurse yelled at spended and counseled on rnout. Also gave her |                     |  |             |                          |
|                          | documented, "The da<br>spent a majority of the  | y CMA #3, dated 02/23/21,<br>y of 2-22-21, [resident #7]<br>e day sitting in the North Hall<br>nother resident]s room. At   |                     |  |             |                          |

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| NAME OF PROVIDER OR SUPPLIER  THE COMMONS  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD ENID, OK 73706  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)   | STATEMENT OF DEF   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | T · ·              |   |                                  | E SURVEY<br>PLETED |  |
|--|--|--|--|--------------------|---|----------------------------------|--------------------|--|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD ENID, OK 73706   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  |  |  |  | A. BUILDING:       |   |                                  |                    |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 SOUTH OAKWOOD ROAD  ENID, OK 73706   (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  10 PROVIDER'S PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE)  COMPLETED TO THE APPROPRIATE DATE   |  |  | NH2407   | B. WING            |   | 07                               | -                  |  |
| THE COMMONS  301 SOUTH OAKWOOD ROAD ENID, OK 73706   (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  (X5) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)  | NAME OF PROVIDE  | R OR SUPPLIER  | STREET AD  | DRESS, CITY, STATE | . ZIP CODE                                    | •                                |                    |  |
| THE COMMONS  ENID, OK 73706   (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ENID, OK 73706  ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE   |  |  |  |                    |   |                                  |                    |  |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | THE COMMONS  |  |  |                    |   |                                  |                    |  |
| LL902 Continued From page 212 LL902  | PREFIX   | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL   | PREFIX             | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T | TON SHOULD BE<br>THE APPROPRIATE | COMPLETE           |  |
| approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] 'get the hell out of here, you're not going to sit up here while I'm here.' [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room. During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event"  A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [resident #7] the resident came strolling up to the wanted to sit up here She sid I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not stifting up here Im not gonna [sic] deal with your Ass. so [resident #7] at in the Corner til [LPN #3] left he was very upset the rest of the evening"  A written statement by CNA #3, dated 02/24/21, documented, "The other day! was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to | approhimse static outside Imme and yelled at he to he again talk to [reside nurse his resitting entire.]  A write docu #4] c sitting came nurse arour said and he screen your deal Corner of the A write docu getting at [reside nurse arour said and he screen your deal corner of the A write docu getting at [reside nurse arour said and he screen your deal corner of the A write docu getting at [reside nurse arour said and he screen your deal corner of the A write docu getting at [reside nurse arour said and he screen your deal corner of the A write docu getting at [reside nurse arour said and he screen your deal corner of the A write docu getting at [reside nurse arour said and he screen your deal corner of the A write docu getting at [reside nurse arour said and he screen your deal corner of the around the a | oximately 2 p.m. elf in his wheelch area and parked of the wound ediately the chargy elled to [residen you're not going." [Resident #7] dat [LPN #3]. It is the hell out to me that way." dent #7] wheeled e's station area be comDuring this g in a chair beside event"  Itten statement by mented, "On Morame into work I way at nurses station area be to strolling up to the station [LPN # and and go back I I dont care Im not he said he wanted are are dath im and [sic] not sitting up with your Ass. so the till [LPN #3] left is evening" | [resident #7] wheeled hair up closer to the nurse's ed himself in his wheelchair care nurse's office.  ge nurse, [LPN #3], stood up it #7] "get the hell out of g to sit up here while I'm did raise his hands and do not know what he yelled often hard to make out due [LPN #3] then yelled at him it of here, you're not going to After this occurrence, I himself away from the back down the hall towards occurrence, [CMA #4] was de me and witnessed the set gonna [sic] deal with you and to sit up here She said "I dont give a dam [sic] ip here Im not gonna [sic] in the fit he was very upset the rest of the common in the said he has rights of the common and the said in the gonna [sic] in the fit he was very upset the rest of the was very upset the rest of the common in the said in the gonna [sic] in the fit he was very upset the rest of the common in the said in the gonna [sic] in the fit he was very upset the rest of the was very upset the rest of the common in the said in the gonna [sic] in the fit he was very upset the rest of the w | LL902              |   |                                  |                    |  |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | ` '                                  | (X2) MULTIPLE CONSTRUCTION (X3) I A. BUILDING:                              |                                    |                          |
|--------------------------|---|---|--------------------------------------|---|------------------------------------|--------------------------|
|                          |   | NUMBER  | B. WING                              |   | 0.7                                | C                        |
| NAME OF D                |   | NH2407  |                                      | ZID CODE  |                                    | //01/2021                |
|                          | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE<br>TH OAKWOOD RO |   |                                    |                          |
| THE COM                  | MONS  | ENID, OF  |                                      |   |                                    |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902                    | listen to it. Go to you Im sick of him acting  A written statement b 5:00 p.m., documente [administrator (admin back [and] was told the against me for yelling Monday February 22 [approximately] [2:00 the man but suppose [admin] via the camer told I told male reside hall or go to his room to sit in the area by wit congests the hallwastowards the resident.  A investigative summ "Who is/are the rep #7]Who is/are the rep #7]Who witnessed [CNA #3], [CMA #4] happenedResident sitting near the nurse came down the hall a leave the deskWha resident (s)? Was the resident has had outbreason a staff member should this incident was not victim want to happer discuss the incident, would like to happen, shoulderWhen did to 2pm on Feb [Februar | r room. [LPN #3] then said like this"  y LPN #3, dated 02/24/21 at ed, "Missed a call from of the commons. Called the ed, "Missed a call from of the commons. Called the ed, "Missed a call from of the commons. Called the ed, "Missed a call from of the commons. Called the ed, "Missed and allegation of the commons. Called the ed, and the commons. C | LL902                                |   |                                    |                          |

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|                          | FOF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|--|-------------------------------|
|                          |  |   | A. BUILDING: _      |  |                               |
|                          |  | NH2407  | B. WING             |  | C<br>07/01/2021               |
|                          |  | NH2407  |                     |  | 07/01/2021                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STAT   | TE, ZIP CODE   |                               |
| THE COM                  | MONS   |   | TH OAKWOOD R        | ROAD   |                               |
|                          |  | ENID, OK  | 73706               |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETE                 |
| LL902                    | Continued From page  | 214   | LL902               |  |                               |
| LL902                    | An Oklahoma Board submitted date 02/26 Name: [LPN #3]Did or Criminal Behavior. abuseDescription o suspended pending the returned to work on 0 disciplinary action writed a resident and for concontrary to recognize employment at the farman of the faction of the facility failed to pabuse during the investment of the administrator and not completed.  On 06/23/21 at 2:24 pto describe the incide 02/22/21 with resident resident is hard of hed didn't yell. She stated took statements from and discussed the incide of t | of Nursing complaint form, /21, documented, "Nurse's incident include MisconductYes: Patient f InvestigationLPN was he investigation and 2/26/2021. She received te up for raising her voice at inducting herself in a manner d standards. Her cility is being retained"  Deriod from 02/14/21 to d LPN #3 worked til 6:48 PN #3 worked approximately es after the abuse occurred.  Protect residents from further estigation.  Proof the allegation timely to a through investigation was out., the admin was asked int that happened on | LL902               |  |                               |
|                          | 02/22/21. She stated asked when the incid stated she was notific was asked what the co   | she didn't know. She was<br>ent was reported. She<br>ed on the following day. She<br>outcome of her investigation<br>as substantiated that LPN #3   |                     |  |                               |
|                          | did it. She stated she<br>write up. She was as   | e was suspended and had a<br>ked if the facility had a zero<br>She stated, "If I say yes, my  |                     |  |                               |

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|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|---------------------|---|-------------------------------|--------------------------|
|                          |  |   | _                   |   |                               | :                        |
|                          |  | NH2407  | B. WING             |   | 1                             | 1/2021                   |
| NAME OF PI               | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                               |                          |
| THE COM                  | MONS   |   | OAKWOOD F           | ROAD  |                               |                          |
|                          |  | ENID, OK  | 73706               |   | 1                             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| LL902                    | Continued From page  | 215   | LL902               |   |                               |                          |
| LL902                    | hand book is wrong." done to protect and p to other residents. Sh anything else other th was asked who the st abuse to. She stated asked when the staff did they report timely. asked if the staff who in serviced about repo "Nothing in writing."  On 06/24/21 at 1:09 p verbal abuse happene p.m. She stated "Yes continued to work afte was asked if LPN #3 residents, how were t stated," They couldn't about it." She was as report the abuse imm protected. She stated  The ADM was asked after the incident. Sh  The staff members who not immediately report worked with the victin approximately four ho | She was asked what was revent this from happening he stated they didn't add an what was in place. She taff can report suspected, "Any authority." She was had witnessed the abuse, She stated, "No." She was witnessed the abuse were orting timely. She stated, "O.M., the DON was asked if ed on 02/22/21 around 2:00 st." She was asked if LPN #3 er. She stated, "Yes." She continued to work with he resident protected. She is be, because we didn't know sked, since the staff failed to ediately, were the residents if the resident was assessed the stated, "No."  The witnessed the abuse didn't it. As a result, LPN #3 in and other residents for burs and 48 minutes. | LL902               |   |                               |                          |
|                          | place to prevent abus<br>result, one of the witn<br>allegation of verbally<br>The facility substantia<br>terminated CMA #4 w<br>employed by the facil  | hile LPN #3 continued to be ity.  |                     |   |                               |                          |
|                          | 3. Resident #5 was a   | dmitted to the facility with  |                     |   |                               |                          |

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|                          | FOF DEFICIENCIES OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                   |                     | CONSTRUCTION  | (X3) DATE S |                          |
|--------------------------|---|--|---------------------|---|-------------|--------------------------|
|                          |   |  | A. BUILDING: _      |   |             |                          |
|                          |   | NI42407  | B. WING             |   |             | 04/2024                  |
|                          |   | NH2407   |                     |   | 1 07/0      | 01/2021                  |
| NAME OF P                | ROVIDER OR SUPPLIER                           | STREET AI  | DDRESS, CITY, STA   | TE, ZIP CODE  |             |                          |
| THE COM                  | MONS  |  | TH OAKWOOD F        | ROAD  |             |                          |
|                          |   | ENID, OF   | 73706               |   |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                              | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE    | (X5)<br>COMPLETE<br>DATE |
| LL902                    | Continued From page                           | 216  | LL902               |   |             |                          |
|                          | diagnoses which inclu                         | uded dementia.   |                     |   |             |                          |
|                          | documented the resid                          | ssessment, dated 05/02/21,<br>lent's cognitive skills for<br>was severely impaired.  |                     |   |             |                          |
|                          |   | ort form, dated 06/07/21,<br>dentInvolved[resident                                   |                     |   |             |                          |
|                          | Abuse/Mistreatment                            |  |                     |   |             |                          |
|                          | IncidentReceived a                            | <u> </u>   |                     |   |             |                          |
|                          | towards a resident by                         | staff member. Staff<br>pending investigation"  |                     |   |             |                          |
|                          | member suspended p                            | ending investigation   |                     |   |             |                          |
|                          | A written statement fr<br>06/07/21, documente | om CMA #2, dated<br>d "Around [8:30 a.m.] [CNA                                       |                     |   |             |                          |
|                          | #2] asked me if I coul                        | d come help her I told her   |                     |   |             |                          |
|                          | , , ,   | cond because I was in the  |                     |   |             |                          |
|                          |   | of another Resident. When<br>t #5]'s room [CNA #2] had                               |                     |   |             |                          |
|                          |   | t arm yanking [and] pulling  |                     |   |             |                          |
|                          |   | slapping at his left leg,-on   |                     |   |             |                          |
|                          |   | her to stop doing him that   |                     |   |             |                          |
|                          |   | e what [and] just kind of  |                     |   |             |                          |
|                          |   | the bed, she went to pull on   |                     |   |             |                          |
|                          |   | I told her to just leave that I<br>n. I brought him out for                          |                     |   |             |                          |
|                          |   | e Charge Nursewhat had   |                     |   |             |                          |
|                          |   | n [LPN #2] talked to [CNA  |                     |   |             |                          |
|                          | _   | y away from direct care of   |                     |   |             |                          |
|                          |   | seen [sic] D.O.Naround   |                     |   |             |                          |
|                          |   | [LPN #2] had talk to her   |                     |   |             |                          |
|                          |   | at had happened She told<br>e but now she is [and]                                   |                     |   |             |                          |
|                          | asked me to write out                         |  |                     |   |             |                          |
|                          | askod mo to winto out                         | a datomont   |                     |   |             |                          |
|                          | A written statement fr                        | om LPN #2, dated 06/07/21,   |                     |   |             |                          |
|                          | documented, "[CMA#                            | <sup>‡</sup> 2] came to me and stated "I   |                     |   |             |                          |
|                          |   | cause she came out to ask  |                     |   |             |                          |
|                          | me to help get him [re                        | esident #5] up I went into the   |                     |   |             |                          |

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Oklahoma State Department of Health

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` '               |   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|---|-----------------------------------|-------------------------------|--|
|                          |   |  | A. BUILDING:        |   |                                   | _                             |  |
|                          |   | NH2407   | B. WING             |   | 0.7                               | C<br><b>7/01/2021</b>         |  |
|                          |   |  |                     |   | 1 07                              | 70 17202 1                    |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STATE |   |                                   |                               |  |
| THE COM                  | MONS  | 301 SOU<br>ENID, OK  | TH OAKWOOD RC       | IAU   |                                   |                               |  |
| 0/0.15                   | STIMMADA ST   | ATEMENT OF DEFICIENCIES  |                     | PROVIDER'S PLAN OF  | COPPECTION                        | 0/5)                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| LL902                    | Continued From page   | 217  | LL902               |   |                                   |                               |  |
|                          | at her states she saw<br>at his left leg so I told<br>finish him, I went to [0<br>happened she said I<br>never hurt anyone wa<br>room"  | and he was mad and hitting her grab his arm and swat her to leave and I would CNA #2] and asked what was just playing and I would as told by nurse to stay out of om CNA #2, dated 06/07/21,   |                     |   |                                   |                               |  |
|                          | documented, "[residesided [sic] to get his then uncovered him so was getting him dress his pull-up on the [sic after that I took his hor ready to put his arm is went to put his head I me. got his head in the shirt down. tried to si on leg to Push Leg in have my other hand a him sit up. then holle stand him to finish ge was fighting me. I was [sic] him down to resus [CMA #2] came in the hold him up. then told the [sic] she would ge abusing him. I Left the room. then the nurse her no i was patting him. | dent #5] was awake. So m up. got his clothes ready started talking to him while sed. I started by putting [sic] ] then i put his pants on. ospital gown off. got his shirt n. then put the arm in as I his shirt, I told him not to Bite he whole [sic] [and] pull his t him up By Putting my arm a sitting position while i haround upper back to help red [sic] at [CMA #2] to help ting dressed. Because he has patting hisleg to clam hare [sic] it was ok. then heir [sic] saw i was trying to hid me Let him lay Back down |                     |   |                                   |                               |  |
|                          | "Who isthe report<br>#5]who isreported<br>#2]What happened<br>yanking on Residents  | mary, undated, documented,<br>ed victim[resident   |                     |   |                                   |                               |  |

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STATE FORM 6899 C7JI11 If continuation sheet 218 of 227

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|----------------------------|---|-------------------------------|--|
| ANDILAN                  | or contribution   | IDENTIFICATION NOMBER.   | A. BUILDING: _             |   |                               |  |
|                          |   | NH2407   | B. WING                    |   | C<br>07/01/2021               |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA            | TE, ZIP CODE  |                               |  |
| THE COM                  | MONS  | 301 SOUTI<br>ENID, OK  | I OAKWOOD F<br>73706       | ROAD  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE                   |  |
| LL902                    | around the resident unurse on the hall and sent home pending in DONWhat is the his the incident foreseeal of being combative to deliveredWhen did happen06/07/21, [7 supervisory/managen about the incident[1]  A final state report, da "A skin sweep was by two nurses with not Accused perpetrator of 06/07/2021 pending a 06/08/2021 she was of the Administrator. Shor what could be consalso completed a Reli Understanding Deme perpetrator was allow 06/08/2021"  CNA #2's time sheet, documented she world a.m. to 10:04 a.m., ard a.m. and on 06/08/21 and from 1:57 p.m. to The facility had documented she world a.m. to 10:04 a.m., ard a.m. and from 1:57 p.m. to The facility had documented she world a.m. to 10:04 a.m., ard a.m. and from 1:57 p.m. to The facility had documented she world a.m. to 10:04 a.m., ard a.m. and and on 06/08/21 and from 1:57 p.m. to The facility had documented she world a.m. to 10:04 a.m., ard a.m. and and a documented she world a.m. to 10:04 a.m., ard a.m. and a documented she world a.m. and a documented she w | raff member was told not go ntil further notice by the then was suspended and exestigation by the story of the resident Was obeResident has a history staff when cares are the incident and incident and incident and incident are suspended on an investigation. On counseled by the DON and the received verbal education sidered to be abuse. She has Training entitled and incident and incident are to incident of the incident and investigation. On counseled by the DON and the received verbal education sidered to be abuse. She has Training entitled and incident and incident of the incide | LL902                      |   |                               |  |
|                          |   | an incident report, remove   |                            |   |                               |  |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 219 of 227

Oklahoma State Department of Health

|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE       | (X3) DATE SURVEY<br>COMPLETED   |                 |
|--------------------------|---|--|---------------------|---|-----------------|
|                          |   |  | A. BUILDING: _      |   |                 |
|                          |   | NH2407   | B. WING             |   | C<br>07/01/2021 |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, STAT  | TE, ZIP CODE  |                 |
| THE COM                  | MONS  |  | TH OAKWOOD R        | OAD   |                 |
| 1112 00111               |   | ENID, OK   | 73706               |   |                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE     |
|                          | staff on the hall that the complete safe survey the section of the hall was asked if staff wor stated not always. Street considered interviewing on other halls. She stother staff but not oth asked when the investigation of the investigation.   | se statements from other the incident occurred and is on cognitive residents on the incident occurred. She she was asked if she incident occurred in the incident occurred. She is was asked if she incident in the incident occurred. She incident in the incident occurred in the incident occurred. She incident occurred in the incident occurred in t |                     |   |                 |
|                          | thorough investigation stated, "I feel it was the resident was assed delayed injury. She so the was asked when 06/07/21. She stated lunch and when she resuspended and sent I she worked on 06/08/here at 8:30 a.m. to me Relias training then rewas asked what discipreceived. She stated about dementia, she wand two and a half how was asked what correplace to prevent further | n was conducted. She norough." She was asked if essed after incident for tated, "No."  CNA #2 had worked on she left at 10:04 a.m. for   |                     |   |                 |
|                          | The DON stated she happened because C and she called the CN acknowledged staff dithe incident in a time!  | didn't feel the allegation NA #2 left the door open AA for help. She id not notify DON or ADM of y manner.   |                     |   |                 |

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STATE FORM 6899 C7JI11 If continuation sheet 220 of 227

Oklahoma State Department of Health

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                  | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|----------------------|--|-------------------------------|--|
|                          |  |   | 7 50.25 10.          |  | С                             |  |
|                          |  | NH2407  | B. WING              |  | 07/01/2021                    |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA      | TE, ZIP CODE   |                               |  |
| THE COM                  | MONS   | 301 SOUTH<br>ENID, OK 1   | I OAKWOOD I<br>73706 | ROAD   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE                   |  |
| LL902                    | and a half to two and investigation was not interviewing other statit is unknown if other involved.  4. Resident #8 had dipressure ulcer to the vacuum (vac) and paid A time record for RN documented she work a.m.  A time record for CNA documented she work a.m.  A progress note, date documented, "She she was raped by 50 minutesStaff is not at themselves. This was per policy"  On 06/28/21 at 5:20 a observed to be at the When approached, the a call that a resident in the themselves. They were asked whe call. One stated, "About the two ladies home." | ents for approximately one a half hours. A thorough completed by not ff and residents. As a result, residents had been iagnoses which included sacrum requiring a wound in.  #2, dated 06/27/21, ked from 5:33 p.m. to 5:39  A #5, dated 06/27/21, ked from 10:01 p.m. to 5:39  A #6 do 6/28/21 at 4:23 a.m., than [sic] began saying that females every 30 to go in her room by a reported to administration  a.m., two police officers were front door to the facility. The set of the pout five minutes ago."  A ministrator stated, "I need to be stated, "We have a crazy as raped and I didn't send | LL902                |  |                               |  |
|                          |  | [Resident #8]Allegations  |                      |  |                               |  |

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STATE FORM 6899 C7JI11 If continuation sheet 221 of 227

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| , ,                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE C     |  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|--|-------------------------------|
|                          |   |  | A. BUILDING:        |  |                               |
|                          |   | NH2407   | B. WING             |  | C<br>07/01/2021               |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AI  | ODRESS, CITY, STATE | E, ZIP CODE  |                               |
|                          |   | 301 SOU  | TH OAKWOOD RO       | OAD  |                               |
| THE COM                  | MONS  | ENID, OF   | 73706               |  |                               |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE                |
| LL902                    | of Abuse/Mistreatmer IncidentResident m being raped by 50 pe was also saying we w when staff CMA gave [signs/symptoms] of pday and final reports, of the investigation\$  A report summary, da completion 06/28/21 a "Who is/are the rep woman and 50 of the happenedAccusation bugsWhat was done from further harmStroom 2 at a timeWho of the incidentNotifithe resident's current statusAssessment of 06/28/21When was supervisor/managem about the incident1  A statement from RN "2305-2315 [11:05] began saying that the The bed was checked sign of bugs. She that she was raped. She allegations. She said woman and there is 5 She cannot really designing in her room with being told by Adminisin with 2 Licensed nu | atDescription of akes allegation that she was ople every 30 minutes. She were trying to poison her her ultramNo S/S obysical rape notedFor 5 please include a summary See attached  Atte and time of report at 5:10 p.m., documented, orted perpetrator(s)A mWhat on of Rape and bed to protect the resident(s) taff was to always go in that was done upon discovery ed AdministratorWhat is physical done at 5PM facility ent staff first contacted 1:47 PM [06/27/21]"  #2 documented, p.m. to 11:15 p.m.] Resident there was bed bugs in her bed. If the see that the rapest [sic] is a second them every 5 minutes. Secribe themStaff has been the 2 people and then after tration we have been going | LL902               |  |                               |
|                          |   | hortly after she started   |                     |  |                               |

Oklahoma State Department of Health

STATE FORM 6899 C7JI11 If continuation sheet 222 of 227

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CO  |                     |  | E SURVEY<br>PLETED               |                          |
|--|---|---|---------------------|--|----------------------------------|--------------------------|
|  |   |   | B. WING             |  |                                  | С                        |
|  |   | NH2407  | B. WING             |  | 07                               | //01/2021                |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREETA   | DDRESS, CITY, STATE | , ZIP CODE   |                                  |                          |
| THE COM  | MONS  |   | TH OAKWOOD RO       | AD   |                                  |                          |
|  | OLIMANA DV. OT  | ENID, OF  |                     | DDOL/IDEDIO DI AN OF   | CORRECTION                       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| LL902  | Continued From page   | e 222   | LL902               |  |                                  |                          |
|  | everyone has been ra  | d she was raped and that<br>aped. She said that she has<br>minutes by 50 people"  |                     |  |                                  |                          |
|  |   | 6/28/21, from CNA #7,<br>ent stated she was being<br>peatedly"  |                     |  |                                  |                          |
|  | A statement, dated 06/28/21, from CMA #5 documented, "On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming"   |   |                     |  |                                  |                          |
|  | had received a text m<br>nurse last night at 11<br>resident's wound vac<br>was observed to be r<br>from the charge nurse<br>when the nurse went<br>resident alleged rape<br>the nurse had informe<br>to go in there alone.<br>told the nurse to go a<br>get a description of w<br>The nurse told the AE<br>female rapist and 50 | a.m., the ADM stated she nessage from the charge :14 p.m. that stated the had alarmed. The ADM eading the text messages e as we spoke. She stated in to check the alarm, the . The administrator stated ed her she had told staff not The administrator stated she sk when it happened and that the person looked like. DM the resident reported a people every 30 minutes. d the ADM that the rapist |                     |  |                                  |                          |
|  | with the resident last<br>She stated she had in<br>the family and physic<br>resident. She stated<br>assessed. The adminurse, "You can't rap-<br>close to." She was a  | how many staff had worked night. She stated, "Two." nstructed the nurse to inform ian and to assess the the resident refused to be nistrator stated she told the e someone you can't get sked who the two staff were g with the resident. She   |                     |  |                                  |                          |

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STATE FORM 6899 C7JI11 If continuation sheet 223 of 227

Oklahoma State Department of Health

| ` '  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--|--|---|---------------------|--|-------------------------------|
| AND I DAN OF CONTROL O |  | A. BUILDING: _  |                     |  |                               |
|  |  | NH2407  | B. WING             |  | C<br>07/01/2021               |
| NAME OF P  | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STAT  | E, ZIP CODE  |                               |
| THE COM  | IMONS  | 301 SOU   | TH OAKWOOD R        | OAD  |                               |
| THE COM  |  | ENID, OF  | 73706               |  |                               |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFE DEFICIENCY) | D BE COMPLETE                 |
| LL902  | Continued From page  | 223   | LL902               |  |                               |
|  | stated it was a CNA a  | nd an RN.   |                     |  |                               |
|  | residents once she wallegation of rape. She with two, always two. facility policy was for was an allegation of a find the policy." She reading it. She stated them, suspend." She two staff had been su at the time." She stated She was asked what She was asked if her employees for allegat followed. She stated, "I don't kn She was asked if her employees for allegat followed. She stated, "I don't kn She was asked what She stated, "I don't kn She was asked what She stated, "I don't kn She was asked if her employees for allegat followed. She stated, "I don't kn She was asked if her employees for allegat followed. She stated, "I don't kn She was asked what She was asked if her employees for allegat followed. She stated, "I don't kn She was asked what stated, "I don't kn She was asked what She was asked if her employees for allegat followed. She stated, "I don't kn She was asked if her employees for allegat followed. She was asked what She | a.m., the investigation allegation of rape was M. She stated she based f statements.  OM her interview from reported the charge nurse sident described the slike us" and that the ocumented the resident was ription. The ADM stated, discrepancies in s asked if she was discrepancies. She stated, t say." Reviewed her day that she stated the nurse escription the resident stated the report documented the odescribe the perpetrator. |                     |  |                               |

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Oklahoma State Department of Health

| ` '                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C     |  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|--|-------------------------------|
|                          |  | A. BUILDING:  |                     |  |                               |
|                          |  | NH2407  | B. WING             |  | C<br>07/01/2021               |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE | , ZIP CODE   |                               |
| THE COM                  | MONS   | 301 SOU   | TH OAKWOOD RO       | DAD  |                               |
| THE COM                  | III ON O   | ENID, OF  | 73706               |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE                 |
| LL902                    | LL902 Continued From page 224  |   | LL902               |  |                               |
|                          | facility all night after the   | emained working at the<br>he allegation of rape and the<br>e RN and CNA as the ones   |                     |  |                               |
|                          | The facility failed to have an accurate a thorough investigation into the allegations.   |   |                     |  |                               |
|                          | 5. Resident #6 had diagnoses which included Huntington's disease.  |   |                     |  |                               |
|                          | A resident assessment, dated 02/15/21, documented the resident's cognition was intact.   |   |                     |  |                               |
|                          | A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.  A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back"   |   |                     |  |                               |
|                          |  |   |                     |  |                               |
|                          | documented, "Alleg MistreatmentDescri IncidentAdministrati director that activity a statement, that she of F****** Christ, [Reside notified he had fallen. The nurse is suspend complete" A facsim documented the repo 03/22/21 at 4:22 p.m. | ption of or was notified by Activity ide reported to her in a verheard a nurse say "Jesus ent #6] really? when she was Nurse is not on shift today. led until investigation is nile (fax) cover sheet, rt was sent to the OSDH on |                     |  |                               |
|                          | The facility did not rep   | port the allegation of abuse<br>e Department of Health  |                     |  |                               |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|---|-------------------------------|--|
|   |  |   | 7. Boilesines.                           |   | С                             |  |
| NH2407  |  | B. WING   |  | 07/01/2021  |                               |  |
| NAME OF PROVIDER OR SUPPLIER STREET ADDR            |  |   | RESS, CITY, STA                          | TE, ZIP CODE  |                               |  |
| THE COM   | MONS   | 301 SOUTH<br>ENID, OK   | I OAKWOOD F<br>73706                     | ROAD  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE                 |  |
| LL902   | Continued From page  | 225   | LL902                                    |   |                               |  |
|   | within the required tw   | o hours.  |  |   |                               |  |
|   | A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.   |   |  |   |                               |  |
|   | A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the followingFor 5 day and final reports, please include a summary of the investigationFace Sheet attached, investigation attached"  |   |  |   |                               |  |
|   | Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:  1. Do you feel like when you turn on your call light, you get everything you need taken care of?  2. Have you heard staff using inappropriate language?  3. Has staff ever yelled or spoken harsh to you?  4. If you feel like your needs aren't met, do you know who to talk to?  No negative answers were documented.  LPN #1 reamained working after the allegation of verbal abuse had been made and throughout the invesitigation. |   |  |   |                               |  |
|   |  |   |  |   |                               |  |
|   | reporting staff member or other staff with the administrator docume the staff member make others. She documented reported hearing the emember who had material administrator docume incident did not occur   | ented that she had spoken to king the allegation and three inted she spoke with resident the only person who comments was the staff de the allegation. The ented her conclusion was the |  |   |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                 | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|--|---|-----------------|---|-----------------|
|   |  | A. BUILDING:  |                 |   |                 |
|   |  | NH2407  | B. WING         |   | C<br>07/01/2021 |
| NAME OF PI  | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA | TE, ZIP CODE  |                 |
| THE COMMONS  301 SOUTH OAKWOOD ROAD  ENID, OK 73706   |  |   |                 |   |                 |
| (X4) ID   | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID              | PROVIDER'S PLAN OF CORRECTIO  | N (X5)          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETE     |
| LL902   | Continued From page  | 226   | LL902           |   |                 |
| LL902   | when LPN #1 worked<br>she worked til 3:21 p.<br>did the LPN receive. | on 03/21/21. She stated m. What disciplinary action The DON stated, "None." the investigation had b | LL902           |   |                 |
|   |  |   |                 |   |                 |
|   |  |   |                 |   |                 |

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