STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375195	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodward Skilled Nursing and Therapy	429 E Downs Avenue Woodward, OK 73801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a 2 person transfer was completed per the care plan for 1 (#1) of 3 sampled residents reviewed for accident hazards. The DON identified 43 residents resided in the facility and 17 residents required two staff members to transfer. Findings: On 04/22/25 at 3:08 p.m., Resident #1 was observed in their room, sitting in their recliner, with a mechanical lift sheet under them. Resident #1 did not answer questions appropriately or would answer, I don't know. On 04/23/25 at 12:52 p.m., CNA #4 and CNA #5 were observed to use a mechanical lift and transfer Resident #1 from their wheelchair to their recliner. Resident #1's Care Plan, dated 06/21/22, read in part, assist x 2 for transfers. Resident #1's Quarterly Assessment, dated 10/23/24, showed Resident #1's BIMS score was a 4, which indicated the resident's cognition was severely impaired. The assessment showed Resident #1 did not have an impairment in their upper extremities. An Incident Report, dated 12/07/24, showed while repositioning a resident, the staff member heard a pop sound and Resident #1 complained of pain to their right arm. The report showed the physician was notified and gave an order to obtain x-rays of the right shoulder. The report showed the results indicated the resident had a broken right humerus. An inservice sheet, dated 12/08/24, showed staff were educated on transferring residents and using a gait belt. Transfer/Gait Belt Competency check off documents, dated 12/08/24 and 12/09/24, showed staff demonstrated adequate staff were available to assist the resident per the care plan. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A Final state report, dated 12/11/24, read in part, During reposition [with a] resident, staff member heard a pop sound. Resident c/o [complaints of] pain to right arm. PCP [primary care physician] notified .Resident is a X2 [times 2] assist with transfers .N/O [new order] received to obtain 2 view x-ray of right shoulder. X-ray obtained and results received and sent to [name withheld]. [Name withheld] stated that resident has a broken right humerus and to put a sling on it .After investigating nurse aide [name withheld] admitted to lifting and repositioning resident under [their] arms with no assist. [CNA #6] admits that [they are] aware [Resident #1] is a two person lift and assist and that [CNA #6] is to use a gate [sic] belt which [they] did not do either, employee terminated on 12/10/24 for failure to follow policy and procedures that resulted in injury to the resident. Resident #1's Quarterly Assessment, dated 12/11/24, showed Resident #1's BIMS score was a 3, which indicated the resident's cognition was severely impaired. The assessment showed Resident #1 did have an impairment in their upper extremities on one side. Compliance Rounds, dated 12/09/24 through 12/13/24, 12/18/24, 12/29/24, and 01/08/25 were completed. The compliance rounds consisted of asking staff how to find what level of care the resident required and watching to see if residents were transferred and positioned properly. A policy titled Stand Assist Lift Guideline, dated 02/2025, read in part, Specific methods of transferring and lifting will be designated for each resident. The designated method for the transfer type will be accessible to all staff who perform lifting and transferring and is contained in the care plan. On 04/25/25 at 10:20 a.m., the DON was asked to describe the incident that occurred with Resident #1. The DON stated CNA #6 did not follow the policy and that was how Resident #1's arm was broken. The DON stated, after the incident, the facility inserviced staff, had staff complete transfer/gait belt competency check offs, and compliance rounds had been completed.