STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375290	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Health Center	1153 Cherokee Street Wakita, OK 73771

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure:a. wounds with an infection were covered during meal time to prevent spread of infection for 1 (#5); andb. wound care was provided in a manner to prevent contamination for 1 (#10) of 3 sampled residents reviewed for wound care; andc. proper glove usage during colostomy care for 1 (#8) of 1 sampled resident for ostomy care.The administrator identified one resident with an ostomy and four residents with wounds resided in the facility. Findings: 1. On 04/07/26 at 7:22 a.m., Resident #5 was observed seated in the dining room with wounds on their legs uncovered. On 04/07/26 at 7:35 a.m., RN #1 was observed to don a gown and gloves and applied Silvercel (an anti-microbial wound medication) to Resident #5's right leg wound. RN #1 wrapped Resident 5's right leg with kerlix and Coban, then changed gloves. RN #1 applied Silvercel to Resident 5's left leg wound and wrapped with Kerlix and Coban (wound dressing wraps). RN #1 did not cleanse Resident #5's wounds before applying treatment. An undated Infection Control Policy, read in part, Community Health Center's intent is to prevent and control the transmission of disease and provide maximum protection for our residents, visitors, and staff from the spread of diseases and infections and viruses. A comprehensive assessment, dated 02/16/26, showed Resident #5 was admitted to the facility with multiple drug-resistant organisms and a chronic non pressure ulcer to their right leg. A physician's order, dated 04/07/26, showed Resident #5 was prescribed a midline catheter placement for intravenous antibiotics. The indication for antibiotics was a pseudomonas wound infection. On 04/07/26 at 7:44 a.m., RN #1 stated Resident #5 had a shower before breakfast, so they did not cleanse the wound prior to applying the wound medication. On 04/07/26 at 12:24 p.m., the DON stated Resident #5 was positive for pseudomonas (a bacterial infection) in their wound. They stated Resident #5 was to have a midline intravenous catheter placed for antibiotics. On 04/08/26 at 8:24 a.m., the infection preventionist stated Resident #5 should have never been out of their room without dressings on their wounds. The infection preventionist stated Resident #5 could spread the pseudomonas to others. 2. On 04/07/26 at 8:33 a.m., RN #1 was observed to don a gown and gloves, removed Resident #10's left sock, and cleansed Resident #10's inner left ankle wound with cleanser. RN #1 applied Silvercel to Resident #10's left ankle wound and applied a bandage. RN #1 changed gloves and cleansed Resident #10's outer left ankle wound with cleanser. RN #1 applied Medihoney (a sterilized honey used to treat wounds) with their gloved fingers. RN #1 applied gauze to the wound, and wrapped Resident #10's left foot with Kerlix and Coban. RN #1 applied Resident #10's sock to their left foot, picked up a book and cards from the floor, and handed them to Resident #10. RN #1 doffed their gown and gloves and washed their hands with soap and water. RN #1 did not change their gloves after applying Medihoney to Resident #10's wound. A quarterly assessment, dated 02/14/26, showed Resident #10 was admitted to the facility with multiple drug-resistant organisms and a stage 3 pressure ulcer to their left ankle. On 04/07/26 at 8:45 a.m., RN #1 stated they did not change their gloves after applying Medihoney to Resident #10's wound. RN #1 stated they touched Resident #10's sock, book, and cards with the same gloves they used to apply the wound treatment. They stated they should have changed their gloves or doffed them before touching the items to prevent contamination. 3. On 04/07/26 at 12:26 p.m., the DON was observed providing colostomy care to Resident #8. The DON cleansed the colostomy site and doffed a (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pair of gloves. The DON was observed to have a pair of gloves on underneath the pair they doffed. The DON prepared the colostomy wafer, then doffed their gloves. The DON was observed to have a pair of gloves on underneath the pair they doffed. The DON applied the colostomy wafer and bag to Resident #8's abdomen. The DON doffed their gloves. The DON had a total of four pairs of gloves on at one time. On 04/08/26 at 8:27 a.m., the infection preventionist stated it was not acceptable practice to wear multiple pairs of gloves at one time while providing colostomy care or any direct care. They stated staff must only wear one pair at a time to prevent spread of infection.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure accurate comprehensive assessments for 3 (#10, 18, and #21) of 12 sampled residents reviewed for accurate assessments.The administrator identified 32 residents resided in the facility. Findings: 1. On 04/06/26 at 11:21 a.m., Resident #18 was observed lying in bed with oxygen on at two liters. A physician's order dated 09/03/25, showed Resident #18 was to have oxygen at two liters per nasal cannula to keep oxygen levels greater than 89%. A significant change assessment, dated 03/23/26, showed Resident #18 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of breast, Lewy bodies neurocognitive disorder, atrial fibrillation, and asthma. Resident #18's assessment did not show they used oxygen. 2. On 04/07/26 at 12:35 p.m., Resident #21 was observed seated in a geriatric chair participating in a music activity in which they were holding a drumstick. Resident #21 was observed having difficulty holding the drumstick due to contractures in their bilateral hands. A quarterly assessment, dated 03/15/26, showed Resident #21 was admitted on [DATE] with diagnoses which included cerebral palsy, profound intellectual disabilities, and speech and language disorder. The assessment showed no impairment to Resident #21's upper extremities. On 04/08/26 at 12:43 p.m., the MDS coordinator stated they should have checked oxygen use on the comprehensive assessment for Resident #18 and impairment to upper extremities for Resident #21's quarterly assessment. 3. On 04/06/26 at 1:17 p.m., Resident #10 was observed to have a bandage on their left lower extremity. On 04/07/26 at 8:33 a.m., RN #2 was observed providing wound care to Resident #10's left ankle. A skin evaluation, dated 02/13/26, showed Resident #10 had a stage three pressure ulcer on their left lateral foot that was present on admission. An annual assessment, dated 02/14/26, showed Resident #10 was admitted to the facility on [DATE]. The assessment did not show a pressure ulcer was present for Resident #10. On 04/08/26 at 12:49 p.m., the MDS coordinator stated they should have documented Resident #10's wound on their comprehensive assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for 2 (#18 and #21) of 12 sampled residents reviewed for care plans. The administrator identified 32 residents resided in the facility. Findings: 1. On 04/06/26 at 11:21 a.m., Resident #18 was observed lying in bed with oxygen on at two liters. An undated Care Plan Policy, read in part, Community Health Centers' interdisciplinary team will conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity .This care plan will include measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs .Each resident will be assessed on a quarterly basis and necessary revisions of the care plan will take place with each quarterly review/assessment. A significant change assessment, dated 03/23/26, showed Resident #18 was admitted on [DATE] with diagnoses which included neurocognitive disorder with Lewy bodies, malignant neoplasm of breast, asthma, and atrial fibrillation. A physician's order dated 03/23/26, showed Resident #18 was admitted to hospice services. 2. On 04/07/26 at 12:35 p.m., Resident #21 was observed seated in a geriatric chair participating in a music activity in which they were holding a drumstick. Resident #21 was observed to be having difficulty holding the drumstick due to contractures in their bilateral hands A care plan, updated 12/29/25, showed Resident #21 required total assistance with all activities of daily living. The care plan did not show contractures were present in both hands. A diagnoses report, dated 04/08/26, showed Resident #21 was admitted on [DATE] with diagnoses which included cerebral palsy, developmental speech disorder, profound intellectual disabilities, and dystonia. On 04/08/26 at 12:43 p.m., the MDS coordinator stated they should have included a hospice care plan for Resident #18 and should have included interventions for contractures on Resident #21's hands.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure an as needed psychotropic medication was not used for more than 14 days for 1 (#4) of 3 sampled residents reviewed for unnecessary medications.The DON identified 27 residents utilized psychotropic medications. Findings: A physician's order, dated 01/12/26, showed Resident #4 was prescribed lorazepam (an anti-anxiety medication) oral concentrate 2 mg/ml. The directions for administration were to give 0.5 ml by mouth every four hours as needed for anxiety, restlessness, and/or agitation. There was no end date for this order. A medication administration record, dated 03/2026, showed Resident #4 was given lorazepam oral concentrate 2 mg/ml on 03/06/26, 03/08/26, and 03/14/26. An annual assessment, dated 03/19/26, showed Resident #4 was admitted to the facility with diagnoses which included depression and seizure disorder. On 04/08/26 at 11:59 a.m., certified medication aide #1 stated Resident #4 received lorazepam as needed for anxiety. On 04/08/26 at 12:06 p.m., the DON stated to ensure a resident was free from unnecessary medications, a psychotropic medication would be limited to a 14-day use. The DON stated Resident #4's lorazepam order from 01/12/26 should have had a stop date of 01/26/26 and a new order obtained. They stated, It has fallen through the cracks.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interview, the facility failed to ensure a resident received the correct insulin dosage for 1 (#24) of 1 sampled resident reviewed for insulin administration.The administrator identified two residents in the facility received insulin. Findings: On 04/07/2026 at 8:50 a.m., RN #1 was observed to obtain Resident #24's finger stick blood sugar with a result of 190. RN #1 was observed to administer Fiasp FlexTouch Pen-injector 100 unit/ml (insulin) 9 units subcutaneously to Resident #24's right lower abdomen. An annual assessment, dated 01/14/26, showed Resident #24 had a diagnosis of diabetes mellitus. A physician's order, dated 01/31/26, showed Resident #24 was prescribed Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 unit/ml, inject as per sliding scale: if 70 - 140 = 0; 141 - 180 = 3u; 181 - 220 = 6u; 221 - 260 = 9u; 261 - 300 = 12u; 301 - 340 = 15u; 341 - 500 = 18u. If greater than 341 give 18 units. On 04/07/26 at 8:57 a.m., RN #1 stated they did not know they administered 9 units of insulin instead of 6 units. They stated they would notify the DON of the medication error.