STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375303	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wewoka Healthcare Center	1400 West First Street Wewoka, OK 74884

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on observation, record review, and interview, the facility failed to prevent physical abuse for one (#3) of three sampled residents reviewed for abuse allegations. The administrator identified 76 residents resided in the facility. Findings: An undated facility Abuse Policy and Procedure, read in part We will endeavor to protect our occupants from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse, neglect, and the misappropriation of resident property . A quarterly MDS, dated [DATE], documented Res #3 was severely cognitively impaired, and was dependent on staff for most ADLs. An email correspondence to the ADON, dated 06/07/24 at 8:21 a.m., documented CNA #2 had witnessed CNA #3 grab Res #3's groin with force on their brief. The email documented CNA #3 had yelled at Res #3 during care and was rough during the incontinent care. On 06/12/24 at 1:40 p.m., Res #3 was observed in their bed. They were cognitively unable to participate in an interview. On 06/13/24 at 11:21 a.m., the administrator stated the allegation of abuse was substantiated as a result of their investigation and CNA #3 had been terminated.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46387 Based on record review and interview, the facility failed to ensure an allegation of abuse was reported within 2 hours to OSDH for one (#3) of four sampled residents reviewed for allegations of abuse. The administrator identified 76 residents resided in the facility. Findings: An undated facilty Abuse Policy and Procedure, read in part, .When the allegation involves abuse or results in serious bodily injury you must report within 2 hours of notification of incident . An email correspondence from CNA #2 to the ADON, dated 06/07/24 at 8:21 a.m., documented CNA #2 witnessed potential abuse from CNA #3 towards Res #3. The email documented the incident occurred around 8:00 p.m. on 06/06/24. An incident report was filed with OSDH on 06/07/24 at 9:48 a.m. On 06/13/24 at 10:23 a.m., the administrator stated they were aware CNA #2 did not report the incident within two hours and an inservice had been 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 49701 Based on record review and interviews, the facility failed to investigate an allegation of abuse for two (#2 and #4) of four sampled residents reviewed for abuse. The administrator identified 76 residents resided in the facility. Findings: An undated facilty Abuse Policy and Procedure, read in part, The Administrator or Administrator Designee will conduct an immediate investigation of all alleged or actual incidents of abuse .Documentation .Nursing staff shall document the incident .in the Medical Record . 1. Res #2 had diagnoses that included cognitive communication deficit. A MDS assessment, dated 04/30/24, documented the resident's brief interview for mental status was at a 14/15. 2. Res #4 had diagnoses that included aphasia and dementia with behavioral disturbances. A MDS assessment, dated 05/28/24, documented the resident had severely impaired cognitive skills for daily decision making. On 06/12/24 at 2:06 p.m., CNA #1 stated Res #8 made them aware they witnessed Res #2 force Res #4 into their room and started to strip them. They stated Res #8 told someone to call 911. CNA #1 stated they were on a transport when this was reported to them. They stated the previous social services director also heard the allegation and reported it to the DON. On 06/12/24 at 3:06 p.m., the administrator stated they heard Res #2 had gone to Res #4's room, but they did not make it inside. They stated an incident report was not completed, because staff had reported the residents were only holding hands and were both fully clothed. They stated if they had heard that anyone was undressed, they would have reported it. They stated the incident occurred when several staff were at a convention on 04/29/24 through 05/02/24. On 06/12/24 at 3:51 p.m., Res #8 stated they witnessed Res #2 grab Res #4 and drag them into Res #4's room and shut the door. Res #8 stated their family member opened the door to Res #4's room and they saw Res #2's genitals. They stated their pants were down at their ankles. Res #8 stated Res #2 then locked themselves in the bathroom and did not come out for a few hours. Res #8 stated LPN #1 was in charge at the time. On 06/13/24 at 9:36 a.m., LPN #1 stated they were told by a staff member Res #4 wandered into Res #2's room and Res #2 pulled their pants down. They stated there was no physical contact. LPN #1 stated they moved Res #2 to a private room on the opposite hall. LPN #1 stated they spoke to the DON and were instructed to get statements from everyone that was working. LPN #1 stated the police came to the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/13/24 at 12:02 p.m., the administrator provided 13 investigative witness statements, dated 04/29/24. It was documented staff did not witness the incident. There was no documentation what incident the documents were related to. The statement signed by LPN #1 documented they did not see the incident. There was no documentation related to the incident in Res #2 or Res #4's medical record. There were no documentation assessments were performed. There was no documentation the incident was submitted to the Oklahoma State Department of Health.