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	10/03/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on record review and interview, the facility failed to ensure a scheduled court hearing was attended for one (#3) of two sampled residents reviewed for choices. The BOM identified 68 residents who resided in the facility. Findings: Res #3 had diagnoses which included chronic pain and generalized anxiety disorder. A psychiatric hospital discharge summary, dated 08/12/24, documented Res #3's guardianship court hearing was scheduled to be held on 08/20/24. The note documented a contact phone number for Res #3's public defender. An admission assessment, dated 08/19/24, documented Res #3's cognition was intact. On 09/30/24 at 11:45 a.m., Res #3 was observed ambulating in the lobby. Res #3 stated they missed a scheduled court hearing regarding guardianship on 8/20/24. They stated they had made social services and the administrator aware of the scheduled hearing when they were admitted to the facility on [DATE]. Res #3 stated the facility made no effort to ensure they attended the hearing in person and now they had to wait until the next scheduled hearing date. On 09/30/24 at 12:27 p.m., the BOM stated they had not been made aware of the scheduled court hearing for Res #3 until the day before the hearing. The BOM stated they contacted the public defender and tried to schedule a virtual appearance for Res #3 on 08/19/24, but it was too late in the process. On 10/02/24 at 8:45 a.m., LPN #1 was shown the documentation in Res #3's medical record regarding the court hearing. LPN #1 stated the admitting nurse should have ensured the information was provided to social services when Res #3 was admitted . On 10/02/24 at 9:09 a.m., the social services director stated they were never provided with the information regarding Res #3's court hearing. (continued on next page)

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
	375303	A. Building B. Wing	10/03/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 1:57 p.m., the interim DON stated the admitting nurse should have ensured social services was made aware of the scheduled court appearance for Res #3. They stated the resident missed the appointment due to a lack of communication between the facility staff.

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	10/03/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46582 Based on observation, record review, and interview, the facility failed to ensure residents were bathed as scheduled for one (#1) of three sampled residents reviewed for bathing. The BOM identified 68 residents who resided in the facility. Findings: Res #1 had diagnoses which included edema and morbid obesity. An admission assessment, dated 09/05/24, documented the resident was cognitively intact and dependent with bathing. A facility shower schedule documented Res #1 was to receive a bath/shower on Tuesdays, Thursdays, and Saturdays weekly. There was no documentation of completed baths found in the medical record. On 09/30/24 at 9:15 a.m., Res #1 was observed lying shirtless in bed. Breadcrumbs were observed on and around the resident's upper body. Res #1 stated they had only received three baths since admission. On 10/01/24 at 2:50 p.m., CNA #2 stated completed baths should be documented in the EHR. They stated all refusals should be documented in the EHR or on a paper shower sheet and then given to the charge nurse. On 10/02/24 at 9:50 a.m., the ADON stated there was no documentation of completed baths for Res #1.

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	10/03/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46582 Based on record review and interview, the facility failed to employ a full-time DON and ensure RN coverage for eight consecutive hours, seven days per week. The BOM identified 68 residents who resided in the facility. Findings: On 09/30/24 at 10:00 a.m., the administrator stated the facility had been without a full-time DON for several months. They stated a corporate registered nurse had filled in occasionally as the interim DON. A Timecard Report, dated August 2024, documented no RN coverage for eight consecutive hours on 20 of the 31 days. A Timecard Report, dated September 2024, documented no RN coverage for eight consecutive hours on 20 of the 30 days. On 09/30/24 at 2:27 p.m., the administrator stated the facility had not maintained RN coverage for eight consecutive hours, seven days per week, for several months due to not having a full-time DON. On 10/02/24 at 1:57 p.m., the interim DON stated the facility had been without a full-time DON since 05/15/24. They stated they had not ensured regular attendance in the facility since becoming the interim DON on 08/01/24.

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	10/03/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on observation, record review, and interview, the facility failed to maintain COVID-19 isolation procedures per policy for four (#3, 10, 11, and #12) of nine sampled residents reviewed for infection control. The BOM identified 68 residents who resided in the facility. Findings: A COVID-19 Isolation and Re-Testing protocol, dated 05/15/23, read in part, .Resident that tests positive for COVID-19 will be immediately isolated .They will remain in the area/room for at least 10 days from the onset of symptoms or the first positive test .If they remain asymptomatic for the entire duration of 10 days, they may be removed from isolation 10 days past the first positive test . A Coronavirus Testing policy, dated 05/15/23, read in part, The facility will provide signage and or instruction to all staff and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19 .Staff or residents with signs and symptoms .Outbreaks (any new case arising in the facility) . A COVID testing log, dated 09/09/24, documented eight residents were positive for COVID-19. A nurse's note, dated 09/09/24, documented Res #3 was placed in isolation precautions due to COVID-19 positive test. A nurse's note, dated 09/14/24, documented isolation precautions were discontinued for Res #3. A COVID testing log, dated 09/16/24, documented nine residents were positive for COVID-19. A nurse's note, dated 09/20/24, documented Res #12 was placed in isolation precautions due to a COVID-19 positive test. A COVID testing log, dated 09/23/24, documented two residents were positive for COVID-19. A nurse's note, dated 09/23/24, documented Res #10 was placed in isolation precautions due to a COVID-19 positive test. A nurse's note, dated 09/23/24, documented Res #11 was placed in isolation precautions due to a COVID-19 positive test. On 09/30/24 at 8:40 a.m., no signage indicating the presence of positive cases of COVID-19 was observed upon entry to the facility. (continued on next page)

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	10/03/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/30/24 at 8:42 a.m., CMA #1 was asked if the facility was in outbreak status due to positive cases of COVID-19. CMA #1 stated the facility had been in outbreak status for a couple of weeks now. They stated they were not sure if any residents were still in isolation. CMA #1 stated there might be a couple of residents on the back hall in isolation, but were not sure which residents they were. On 09/30/24 at 8:45 a.m., a tour of the facility was conducted. Signage and a PPE cart indicating COVID-19 isolation procedures was observed on the door and directly outside of room [ROOM NUMBER] on the back hall. No other resident rooms in the facility were observed indicating isolation procedures were in progress. On 09/30/24 at 9:00 a.m., LPN #2 stated they were the charge nurse for the residents on the back hall. They stated they had been off work due to illness last week. LPN #2 stated they did not think any residents were still in isolation precautions. They stated they had not been made aware of who should be in isolation during shift report that morning. On 09/30/24 at 9:10 a.m., CNA #1 was asked how they were made aware of which residents were in isolation precautions. CNA #1 stated isolation precautions signage should be posted on the door and a PPE cart should be outside the room. They stated they were not sure who was still in precautions at this time. On 09/30/24 at 10:00 a.m., LPN #3 stated they were performing COVID-19 testing for all the residents this morning. They stated the facility had been in outbreak status for the past three weeks. They stated testing was being performed weekly on Mondays and as needed for symptomatic residents/staff. LPN #3 stated Res #10 and Res #11 had tested positive last Monday (09/23/24). They stated there was confusion in the facility as to how long positive residents were to be kept in isolation. LPN #3 stated positive residents had been kept in isolation for five days and removed on day six if they were asymptomatic. On 09/30/24 at 10:25 a.m., the corporate interim DON stated Res #11 and Res #12 shared room [ROOM NUMBER] and Res #10 resided in room [ROOM NUMBER]. They stated all three of these residents should have been placed in isolation precautions. The corporate DON stated the residents had not been kept in isolation precautions for at least 10 days per facility policy. On 09/30/24 at 11:45 a.m., Res #3 was observed ambulating in the lobby. Res #3 stated they tested positive for COVID-19 weeks ago. They stated the facility staff were inconsistent on isolation procedures and the amount of time each positive resident spent in isolation. Res #3 stated they were only required to isolate for a few days after they tested positive. On 10/01/24 at 11:00 a.m., the ADON stated COVID-19 isolation procedures had not been followed consistently during the outbreak period in September. They stated Res #3, 10, 11, and #12 had not been isolated for at least 10 days per policy.

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	10/03/2024

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46582 Based on record review and interview, the facility failed to designate an individual as the infection preventionist. The BOM identified 68 residents who resided in the facility. Findings: On 09/30/24 at 9:45 a.m., the administrator was asked to identify the infection preventionist. They stated the infection preventionist was the ADON. There was no documentation of an infection preventionist certification found for the ADON during record review. On 09/30/24 at 12:42 p.m., the interim DON stated they had an infection preventionist certification, but had been on vacation since 09/10/24. They stated the ADON had been responsible for the infection preventionist duties over the past several months. On 10/01/24 at 8:45 a.m., the ADON stated they had the required infection preventionist certification, but had never been asked to perform the duties of the infection preventionist for the facility. They stated the former full-time DON had completed the duties of the infection preventionist. The ADON stated they had tried to manage the Covid outbreak procedures during the past few weeks, but had not completed all the required duties of the infection preventionist role.