

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Wewoka Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>46702</p> <p>Based on record review and interview, the facility failed to ensure a resident received notification when they were within \$200 of the Medicaid resource limit of \$2000 for 1 (#27) of 3 sampled residents reviewed for notifications of trust balances.</p> <p>The BOM identified 33 residents had money in the trust account.</p> <p>Findings:</p> <p>An undated facility policy titled Resident Funds, read in part, Your Corporate office has put in place a system called National Data Care/Resident Fund Management .This system allows the facility to complete yearly reevaluations for Medicaid and Social Security Administration by providing a detailed transaction report.</p> <p>Resident #27's face sheet, dated 12/01/22, showed the resident had a payer source of Medicaid.</p> <p>Resident #27's annual assessment, dated 11/12/24, showed the resident's BIMS score was 15 indicating their cognition was intact for decision making, had upper and lower extremity impairments on both sides, and was dependent for all activities of daily living.</p> <p>Resident #27's trust account ledger, dated 04/21/25, showed a current balance of \$2353.44.</p> <p>There was no documentation in the resident health record the facility had notified Resident #27 when their trust account balance was within \$200 of the Medicaid resource limit of \$2000.</p> <p>On 04/18/25 at 2:52 p.m., Resident #27 stated they were not notified they were within \$200 of the Medicaid resource limit of \$2000.</p> <p>On 04/21/25 at 1:53 p.m., the BOM stated they did not give notice to Resident #27 that they were within \$200 of the Medicaid resource limit because they were unaware of the requirement to do so.</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46653</p> <p>Based on observation, record review, and interview, the facility failed to ensure a clean, comfortable, and sanitary home like environment during 3 of 3 observations.</p> <p>The DON reported 81 residents resided in the facility.</p> <p>Findings:</p> <p>1. On 04/09/25 at 2:04 p.m., an observation was made in Resident #25's room. Under the sink cabinet were black and green spots approximately 20 inches along the back wall of the cabinet. The spots ranged in various sizes from 0.5 inches to 3 inches with a height between 7 to 11 inches. The flooring under the sink had multiple cracks of various sizes and with reddish brown stains.</p> <p>The facility's policy titled Maintenance Service, revised December 2009, read in part, The Maintenance Department is responsible for maintaining the building, grounds and equipment in a safe operable manner at all times .2. Functions of maintenance personnel include, but are not limited to: d. Maintaining heat/cooling fixtures, plumbing fixtures, wiring, etc. [and other things/and so forth], in good working order.</p> <p>On 04/04/25 at 2:11 p.m., the maintenance supervisor stated Resident #25's sink had a bad valve and the spots were mold from the water damage. They stated they did know how long it had been in their room and they did not have any work orders for water damage in the resident's room.</p> <p>46702</p> <p>2. On 04/18/25 at 2:49 p.m., Resident #27 was observed in their bed. The following observations were made:</p> <ul style="list-style-type: none"> a. the bed linens were soiled with brown residue and debris; b. a baby roach was on the resident by their foot; c. the walls of the room had missing paint, were chipped, and the sheet rock was damaged; d. there were stains on the walls at the head of the bed; e. there were dirty, cracked, soiled floor tiles with a brown substance between the tile seams; and f. the window seal had visible dirt, plant debris, and foil weather tape hanging from the window. <p>On 04/21/25 at 4:16 p.m., a tour of the facility was conducted with the maintenance supervisor. The following observations were made:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. room [ROOM NUMBER]'s wall paint was chipped, dirty, soiled with stains, and needed repaired;</p> <p>b. room [ROOM NUMBER] had broken and missing floor tiles, the walls were scuffed, the sheet rock was damaged, and the floor tiles were soiled and damaged; and</p> <p>c. room [ROOM NUMBER] had base boards detached from the wall.</p> <p>A facility policy titled Quality of Life-Homelike Environment, revised 05/2023, read in part, Residents are provided with a safe, clean, comfortable, and home like environment, and encouraged to use their personal belongings to the extent possible . Staff shall provide person - centered care that emphasizes the residence, comfort, independence, and personal needs and preferences . The facility staff and management shall maximize, to the extent possible, the characteristics of the facilities that reflect a personalized, home like setting these characteristics include;</p> <p>a. Clean, sanitary and orderly environment: daily cleaning, and monthly deep cleaning .e. Clean bed and bath linens that are in good condition.</p> <p>Resident #27's annual assessment, dated 11/12/24, showed their BIMS score was 15 indicating their cognition was intact for decision making, had upper and lower extremity impairments on both sides, and was dependent for all activities of daily living.</p> <p>On 04/18/25 at 2:52 p.m., Resident #27 was asked about the condition of their room. They stated they had roaches crawling on them often and it really bothered them. They stated they reported the roaches and concern of the condition of their room to facility staff. Resident #27 stated facility staff never did anything to address their concern. They stated they were obsessive compulsive and wished they could get out of bed to fix the mismatched paint, clean the walls, and mop the floors that were disgusting.</p> <p>On 04/18/25 at 4:29 p.m., house keeping #1 stated behind the two refrigerator stated they saw roaches and dirt. They stated they saw a mouse trap under the resident's bed and mouse droppings on the floor near the closet. They stated they observed the foil tape in the window, the debris, and the dirty window sill. House Keeping #1 stated it needed cleaning. They stated they observed the stains on the wall and they needed to get in there and clean.</p> <p>On 04/18/25 at 4:30 p.m., the administrator stated they observed the mouse droppings in Resident #27's room and the room was in need of a cleaning.</p> <p>On 04/21/25 at 4:17 p.m., the maintenance supervisor was asked if the above observations present as a home like environment. They stated, No.</p> <p>On 04/21/25 at 4:31 p.m., corporate nurse consult #1 stated it was not a home like environment.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>46702</p> <p>Based on record review and interview, the facility failed to prevent abuse for 1 (#31) of 3 sampled residents reviewed for abuse.</p> <p>The DON stated 81 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Abuse Policy and Procedure, dated 07/23/21, read in part, It recognizes residents rights to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any chemical and physical restraints as defined by federal regulation .Social media, pictures, and videos that demean, and or violate the residence, rights, privacy and or dignity are considered forms of abuse and will be treated as such.</p> <p>Resident #31's admission record, dated 11/06/24, showed the resident was admitted with diagnoses which included personal history of traumatic brain injury and dementia.</p> <p>Resident #31's significant change assessment, dated 03/19/25, showed the resident's BIMS score was 9 indicating they were moderately impaired for decision making. The assessment showed they ambulated with a wheel chair and required supervision or touching assistance for all transfers.</p> <p>Resident #31's care plan, revised 11/15/24, showed the resident was at risk for falls due to impaired mobility.</p> <p>On 04/20/25 at 11:06 p.m., the Oklahoma State Department of Health received an anonymous email. The email, read in part, This resident laid in the floor for a long time even when the nurse gas (sic) notified and CNAs were notified. The email had a picture of an unnamed resident on the floor looking at the camera with their hospital gown exposing their bottom.</p> <p>On 04/21/25 at 9:35 a.m., the ADON identified Resident #31 as being the resident on the floor in the picture from the email. The ADON stated the resident in the picture was looking at the camera, the resident could tell their picture was being taken, and the resident could not stop their picture from being taken.</p> <p>On 04/21/25 at 12:14 p.m., LPN #1 was asked if they were the charge nurse over the weekend and if Resident #31 had a fall. LPN #1 stated they were the charge nurse over the weekend. LPN #1 stated Resident #31 was observed on the floor in their room on 04/19/25 due to an unwitnessed fall. LPN #1 was asked what they did after finding the resident on the floor. LPN #1 stated they first took a picture of the resident, then they assessed the resident, and they did not document the fall in the resident's health record because they thought Resident #31 was care planned to be on the floor. LPN #1 was asked what the policy was for taking pictures of residents. They stated they assumed they were not allowed to take pictures of the resident's face or body parts so they scribbled over Resident #31's buttocks in the image. LPN #1 was asked when the photograph was taken. LPN #1 stated the picture was taken on 04/19/25 at 11:31 p.m.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46702</p> <p>On 04/17/25 at 2:22 p.m., the Oklahoma State Department of Health was notified and verified the existence of and immediate jeopardy situation related to the facility's failure to provide supervision to prevent elopement from the facility.</p> <ol style="list-style-type: none"> 1. Resident #26 had moderate impairment for decision making, was a fall risk, and ambulated with a wheel chair. A visitor notified the facility Resident #26 was walking down the road. A CNA went and picked up the resident and returned them to the facility. 2. Resident #30 was identified as being a high risk for elopement. Resident #30 was able to leave the facility without staff aware and was located walking down the state highway in a construction zone three miles from the facility by an off duty staff member and returned to the facility in the staff members vehicle. <p>On 04/17/25 at 2:43 p.m., the administrator, the ADON, and corporate nurse #1 were notified of the immediate jeopardy situation and provided the immediate jeopardy template.</p> <p>On 04/18/25 at 8:46 a.m., an amended plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>On 4/17/2025, elopement risk assessments were initiated on all residents with care plans updated to identify any at risk residents.</p> <ol style="list-style-type: none"> 1. A notification sign will be placed on entrance/exit doors to alert visitors and vendors to not let anyone out without notifying/asking facility staff first. 2. All staff to include nursing, dietary, housekeeping/laundry, maintenance In-Serviced on elopement risk policy, ensuring that identified elopement risk residents are redirected away from doors, and location of list at each nurse's station and in employee break room of wandering/elopement risk residents and to check list at beginning of shift, educated on the reporting party to fill out an incident reporting form with the charge nurse signature, and to place under the Administrators door, and ensuring that doors completely close/latch when entering/exiting the facility. 3. HR [human resources]/BOM in-serviced on all newly hired personnel will be educated on elopement policy, location of list of at risk for elopement residents with an acknowledgement page and ensuring that doors completely close/latch when entering/exiting the facility. 4. All Licensed nurses In-Serviced on elopement policy with emphasis on immediately reporting to the Administrator the instance of an elopement, assessing the resident for injuries with documentation in the progress note of measures put in place to protect resident from further potential elopement with notifications to physician, family, and law enforcement. 5. Administrative staff In-Serviced on reviewing elopement risk resident list/any new admissions and updating list accordingly 5 times weekly during clinical meeting. <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>6. DON/Designee will report any negative findings quarterly to QAPI [quality assurance performance review].</p> <p>7. Any employee that can't be reached for In-Service will be inactive and taken off the schedule until education is provided.</p> <p>8. Maintenance Supervisor will inspect all exit doors 5 times weekly to ensure doors are closing/latching properly.</p> <p>On 04/18/25, facility staff were interviewed by phone and in person. Staff were interviewed regarding inservices completed on elopement. Staff were interviewed and able to communicate elopement prevention strategies, identify residents at risk for elopement, and elopement response policies and procedures. All residents health records were reviewed and verified they contained elopement risk assessment and the ones with a risk were care planned to prevent elopement. Notifications signs for staff, residents, and visitors were verified to be posted on all exits. All doors were verified to be in good working order and locks were in good repair.</p> <p>On 04/18/25, after interviews with staff, review of resident elopement wander risk assessments and care plans, posted signage, and inservices, the immediacy was lifted effective 04/18/25 at 4:54 p.m The deficient practice remained at a pattern with potential for more than minimal harm.</p> <p>Based on record review and interview, the facility failed to:</p> <p>a. prevent elopement for 2 (#26 and #30) of 3 sampled residents reviewed for elopement</p> <p>b. document an unwitnessed fall for 1 (#31) of 2 sampled residents reviewed for falls.</p> <p>The ADON identified five residents at risk for elopement and 25 residents were at risk for falls.</p> <p>Findings:</p> <p>A facility policy titled Wandering and Elopements, revised 03/2019, read in part, 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety .c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident is attempting to leave or has left the premises. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative, the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e. [that is/in other words], Emergency Management, Rescue Squads, etc.)</p> <p>.a. Examine the resident for injuries;</p> <p>b. Contact the Attending Physician and report findings and conditions of the resident;</p> <p>c. Notify the resident's legal representative (sponsor);</p> <p>d. Notify search teams that the resident has been located;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>e. Complete and file an incident report; and</p> <p>f. Document relevant information in the resident's medical record.</p> <p>A facility policy titled Falls-Clinical Protocol, revised 03/2022, read in part, staff and physician will document in the medical record a history of one or more recent falls .The staff will evaluate and document falls that occur while the individual is in the facility .falls should be identified as witnessed or unwitnessed events .the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall.</p> <p>1. Resident #26's admission record, dated 04/03/24, showed the resident was admitted with diagnoses which included vascular dementia and aftercare following surgery on the digestive system.</p> <p>Resident #26's elopement assessment, dated 04/03/25, showed the resident was not at risk for elopement.</p> <p>Resident #26's admission assessment, dated 04/10/25, showed the resident had a BIMS score of 9 indicating moderate cognitive impairment, no history of wandering, ambulated with a wheel chair, and had a history of falling.</p> <p>A weather report on 04/15/25 showed night temperatures of 40 degrees Fahrenheit.</p> <p>Resident #26's elopement assessment, dated 04/16/25, showed the resident was a high risk for elopement.</p> <p>There was no documentation in Resident #26's health record of an elopement.</p> <p>On 04/16/25 at 11:50 a.m., the DON stated Resident #26 was at risk for elopement and had never been reported to elope.</p> <p>On 04/16/25 at 12:17 p.m., LPN #1 was asked about any elopements involving Resident #26. They stated on 04/15/25 around 7:00 p.m., CNA #1 went in the transport van and picked up Resident #26 and returned the resident. LPN #1 stated they reported the elopement to the ADON and the administrator. LPN #1 stated they were not made aware Resident #26 had eloped until CNA #1 went and picked up the resident and returned to the facility with the resident. LPN #1 stated they did not document anything in the resident's health record or complete an incident report.</p> <p>On 04/16/25 at 2:07 p.m., CNA #1 was asked about the elopement. They stated a visitor came in and notified them a resident was about one quarter a mile away from the facility walking on the side of the road. CNA #1 stated they went in the transport van and found Resident #26 walking down the road and picked them up and returned to the facility and notified LPN #1 who was the charge nurse. CNA #1 was asked how they identified what residents were elopement risk. They stated there was a list, but it was not there anymore. CNA #1 stated they relied on the charge nurse to communicate which residents were allowed to leave. They stated the administrator was aware of the elopement and spoke with the resident when they returned.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 04/16/25 at 2:26 p.m., CNA #7 stated a third party notified them Resident #26 eloped on 04/15/25. CNA #7 stated CNA #1 went in the transport van and picked up Resident #26 and they had no idea how the resident got out of the facility. CNA #7 stated the charge nurse let them know who could leave the facility without supervision.</p> <p>On 04/16/25 at 2:40 p.m., CMA #1 stated a visitor from outside came in and notified them on 04/15/25 around 7:30 p.m. an unnamed resident was walking down the road. They stated a CNA went and picked up Resident #26 and notified LPN #1 when they returned.</p> <p>2. Resident #30's admission record, dated 08/23/24, showed the resident was admitted with diagnoses which included schizo-affective disorder, hypothyroidism, and gout.</p> <p>Resident #30's care plan, dated 11/27/24, showed the resident was an elopement risk with interventions including: assess for fall risk and monitor fatigue and weight loss.</p> <p>Resident #30's elopement risk assessment, dated 12/02/24, showed the resident was at risk for elopement and their BIMS score was 14 indicating their cognition was intact.</p> <p>Resident #30's quarterly assessment, dated 02/25/25, showed the resident's BIMS score was 13 indicating their cognition was intact and they no history of wandering.</p> <p>A weather report on 04/07/25 showed night temperatures of 33 degrees Fahrenheit.</p> <p>Resident #30's behavior note, dated 04/07/25 at 9:45 p.m., showed the resident attempted to elope from the building 10 times. The note showed the resident was redirected with minimal effectiveness and was argumentative with staff.</p> <p>Resident #30's elopement risk assessment, dated 04/09/25, showed the resident was at risk for elopement and had BIMS score of 12 indicating moderate cognitive impairment.</p> <p>There was no documentation in Resident #30's health record they eloped on 04/07/25.</p> <p>On 04/16/25 at 7:21 a.m., LPN #5 was asked how they identified residents at risk for elopement. They stated there was no set list and if a resident did not have a power of attorney or guardian, they assumed the resident could leave unsupervised. LPN #5 was asked if any assessment identified residents at risk for elopement. They stated they were not aware of an assessment. LPN #5 was asked about Resident #30 and if they ever eloped. They stated on 04/07/25 at around 9:45 p.m., they were the charge nurse on duty and when the smokers came in they noticed the resident was missing. LPN #5 stated a CMA came and alerted them the resident was missing during a medication pass. LPN #5 stated they started to look for the resident when an off duty CNA called and they stated they found the resident walking down the road. They stated when the resident returned, the resident was covered with fecal matter from incontinence. LPN #5 stated they cleaned up the resident, notified the DON, but did not document anything in the resident's health record.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 04/16/25 at 2:42 p.m., CMA #3 was asked about Resident #30's elopement. They stated on 04/07/25 they were passing medications and could not locate Resident #30 for medication pass. CMA #3 stated they started to look for the resident and then received a phone call from a facility worker (name unknown). CMA #3 stated the facility worker stated the resident was seen on the highway and was picked up and returned to the facility. They stated the resident had mud on their leg like they had a fall. CMA #3 stated the resident was showered and they notified LPN #5. They were asked what the elopement policy was. They stated they were unsure. CMA #3 was asked how they identified residents at risk for elopement. They stated the charge nurse verbally informed them. They stated the resident could of been hit by a car and seriously harmed.</p> <p>On 04/16/25 at 3:59 p.m., Resident #30 was asked to discuss what happened last week. Resident #30 stated they got out of the facility and escaped because they did not want to be there anymore. They stated they were walking down the highway and fell in the mud and a staff member brought them back to the facility.</p> <p>3. Resident #31's admission record, dated 11/06/24, showed the resident was admitted with diagnoses which included personal history of traumatic brain injury and dementia.</p> <p>Resident #31's care plan, revised 11/15/24, showed the resident was at risk for falls due to impaired mobility.</p> <p>Resident #31's significant change assessment, dated 03/19/25, showed the resident's BIMS score was 9 indicating moderate cognitive impairment. The assessment showed they ambulated with a wheel chair and required supervision or touching assistance for all transfers.</p> <p>On 04/20/25 at 11:06 p.m., the Oklahoma State Department of Health received an anonymous email. The email, read in part, This resident laid in the floor for a long time even when the nurse gas (sic) notified and CNAs were notified. The email had a picture of an unnamed resident on the floor in a hospital gown looking at the camera with their exposed buttocks redacted. The image was of Resident #31.</p> <p>There was no documentation in Resident #31's health record a fall occurred over the weekend on 04/19/25.</p> <p>On 04/16/25 at 10:39 a.m., the ADON stated Resident #26 had never eloped and residents with a BIMS score of 13 or more could leave without supervision. The ADON stated Resident #30 had interventions for elopement in their care plan which included assessing for fall risk and monitor for fatigue and weight loss. The ADON stated the interventions in Resident #30's care plan were not appropriate interventions to prevent elopement. They stated they were unaware of Resident #26's elopement on 04/15/25, they were unaware of Resident #30's elopement on 04/07/25, and there was no documentation in the residents electronic health record of the elopements.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Wewoka Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 04/16/25 at 3:39 p.m., CNA #4 was asked about Resident #30's elopement. They stated 04/07/25 at 9:30 p.m. they were off duty and heading home on the state highway about three miles from the facility. CNA #4 stated they saw Resident #30 heading away from the facility walking on the highway in the construction area. CNA #4 stated Resident #30 stated they were cold, they were covered in mud, and had soiled themselves with urine and fecal matter. They were asked how they identify which residents were at risk for elopement. They stated there was a scoring system and charge the charge nurse verbally informs them.</p> <p>On 04/16/25 at 5:20 p.m., the DON was asked how staff identified residents at risk for elopement. They stated it was based on a BIMS score of 12 and below and the charge nurse decided who could leave without supervision. They stated they did not have a good system in place to prevent elopement due to residents' mental health diagnosis and the residents did not follow the rules. They stated if the resident was assessed as an elopement risk it was easier to let them leave or they will just crawl out the window. The DON stated there was no documentation Resident #26 eloped, they were unsure why LPN #1 completed an elopement assessment for Resident #26 on 04/16/25, and they did not know anything about Resident #26's care. The DON stated Resident #30 was an elopement risk, the resident could not leave unsupervised, and they were unaware the resident had eloped on 04/07/25. They stated residents who eloped were at risk for harm.</p> <p>On 04/16/25 at 6:10 p.m., the administrator was asked about their elopement policy. They stated they should be notified of all elopement and complete a state reportable. They were asked about Resident #26's elopement on 04/15/25 and Resident #30's elopement on 04/07/25. They stated there was no documentation Resident #26 and Resident #30 eloped and they were not notified Resident #26 and Resident #30 eloped. They stated residents who had a BIMS score of 13 or above could leave unsupervised. They were asked if Resident #30 who had a BIMS score of 13 could leave unsupervised. They stated no due to Resident #30's mental health diagnosis. They stated Resident #26 had a BIMS score of 9 and should not be allowed to leave unsupervised.</p> <p>On 04/21/25 at 9:35 a.m., the ADON was shown the image from the anonymous email received on 04/20/25 at 11:06 p.m., and asked which resident was on the floor in the image. The ADON stated it was Resident #31. They stated the resident was looking at the camera and could tell their picture was being taken.</p> <p>On 04/21/25 at 10:25 a.m., the administrator was asked if they were notified Resident #31 had a fall over the weekend. The administrator stated the facility was unaware Resident #31 had a fall.</p> <p>On 04/21/25 at 12:14 p.m., LPN #1 was asked if they were the charge nurse over the weekend and if Resident #31 had a fall. LPN #1 stated they were the charge nurse over the weekend. LPN #1 stated Resident #31 was observed on the floor in their room on 04/19/25 due to an unwitnessed fall. LPN #1 was asked what they did after finding the resident on the floor. LPN #1 stated they first took a picture of the resident on the floor, assessed the resident, but they did not document the fall in the resident's health record because they thought Resident #31 was care planned to be on the floor.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46653</p> <p>Based on observation, record review and interview, the facility failed to ensure a treatment cart was secured for 1 of 1 treatment cart observed.</p> <p>The DON identified 81 residents resided in the facility.</p> <p>Findings:</p> <p>On 04/04/25 at 12:26 p.m., the Southwest hall treatment cart observed on the East side of the nurses station was found unlocked and unattended. Resident#12's Lantus SoloStar Subcutaneous Pen-injector 100 units per milliliter (insulin glargine) was observed in the first drawer of the treatment cart.</p> <p>A facility policy titled Medication Storage in the Facility, revised January 2018, read in part, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>On 04/04/25 at 12:27 p.m., LPN #6 stated their policy indicated the treatment cart was supposed to be locked and attended to at all times.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>46653</p> <p>Based on observation, record review, and interview, the facility failed to have a working call lights for 1 of 3 sampled shower rooms used by residents.</p> <p>The DON reported 81 residents resided in the facility.</p> <p>Findings:</p> <p>On 04/04/25 at 1:23 p.m., the call light was found not working in the shower room on the East side of the middle hall.</p> <p>The facility's policy titled Maintenance Service, revised December 2009, read in part, 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p> <p>On 04/04/25 at 1:25 p.m., advanced certified medication aide #2 stated the call light in the middle shower room was not working.</p> <p>On 04/04/25 at 2:14 p.m., the administrator stated the call lights were supposed to work in the shower rooms.</p> <p>On 04/08/25 at 3:30 p.m., the maintenance supervisor stated they had no work orders for call lights.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to maintain an effective pest management program .</p> <p>The DON reported 81 residents resided in the facility.</p> <p>Findings:</p> <p>On 04/18/25 at 2:49 p.m., Resident #27 was observed in bed in their room. The following observations were made:</p> <ul style="list-style-type: none"> a. a roach was on the resident by their foot; b. mouse droppings were on the floor along the walls; and c. a mouse trap at the head of the resident's bed. <p>On 04/18/25 at 4:29 p.m., live and dead roaches were observed behind the refrigerator in Resident #27's room. Mouse droppings were observed in the resident's top drawer of their dresser near the window and along the walls on the floor.</p> <p>An undated facility policy titled Pest Control, read in part, This facility maintains an on-going pest control program to ensure the building is kept free of insects and rodents.</p> <p>Resident #27's admission record, dated 12/01/22, showed the resident was admitted with diagnoses which included dysphagia and major depressive disorder.</p> <p>A facility Pest Sighting Log, dated 02/05/25 through 04/05/25, showed:</p> <ul style="list-style-type: none"> a. on 03/28/25 mice and roaches were sighted in room [ROOM NUMBER] and 4 on the bathroom walls; and b. on 04/05/25 roaches were sighted in room [ROOM NUMBER]. <p>The log showed the last preventative treatment for pests was on 02/26/25. The log did not document the above pest sightings were treated after the sightings were recorded on the log.</p> <p>Resident #27's annual assessment, dated 11/12/24, showed their BIMS score was 15 indicating their cognition was intact for decision making, had upper and lower extremity impairments on both sides, and was dependent for all activities of daily living.</p> <p>On 04/18/25 at 2:52 p.m., Resident #27 was asked about the condition of their room. They stated they had roaches crawling on them often and it really bothered them. They stated they reported the roaches and concern of the condition of their room to facility staff and they never did anything about it.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/18/25 at 4:29 p.m., house keeping #1 stated behind the two refrigerators in Resident #27's room they saw roaches and dirt. They stated they saw a mouse trap under the resident's bed and mouse droppings on the floor near the closet.</p> <p>On 04/18/25 at 4:30 p.m., the administrator stated they observed mouse droppings on the floor in Resident #27's room and in the resident's drawers, and live roaches behind the refrigerator.</p> <p>On 04/21/25 at 4:17 p.m., the maintenance supervisor was asked about pests in the facility. They stated the roaches were still present, but the amount of them had decreased.</p>		