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	06/18/2025

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 - 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. Based on observation, record review, and interview, the facility failed to ensure a resident was not touched sexually by another resident for 1 (#5) of 5 sampled residents reviewed for abuse. The ADON identified 82 residents resided in the facility. Findings: 1. On 06/16/25 at 9:30 a.m., Res #5 was observed sitting on a couch in the common area of the facility. Res #5 was observed smiling, but showed limited communication due to cognitive impairment. An Abuse Policy and Procedure, updated 07/23/21, 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. An undated sexual consent policy, read in part, This policy recognizes and supports the older adult's right to engage in sexual activity, so long as there is consent among those involved. Consent may be demonstrated by the words and/or affirmative actions of an older adult with intact decision-making ability. An undated face sheet showed Res #5 had diagnoses which included focal traumatic brain injury and frontotemporal neurocognitive disorder. A quarterly assessment, dated 05/13/25, showed Res #5 had a BIMS score of 7 and was severely cognitively impaired. A nurse note, dated 06/08/25 at 9:32 p.m., showed Res #5 was sitting on the sofa in the back common area when Res #4 sat down beside them and placed their hand down in their pants on their private area. The note showed Res #4 placed their other hand on Res #5's private area. The note showed staff immediately separated Res #4 from Res #5 and placed Res #4 on 1:1 monitoring. The note showed Res #5 was assessed and had no physical injuries. An Oklahoma State Department of Health initial report, dated 06/08/25, showed a staff member witnessed Res #4 sit down beside Res #5 on the sofa in the common area. The report showed Res #4 leaned down and kissed Res #5 on the cheek while placing one of their hands down the front of their pants onto their private area and the other hand onto Res #4's private area. The report showed the staff member immediately told Res #4 to stop, separated the residents, and began 1:1 monitoring of Res #4. (continued on next page)

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	A care plan, updated 06/09/25, showed Res #5 was at risk for inappropriate touching due to cognitive impairment with an actual incident having occurred on 06/08/25. A mental health care provider note, dated 06/09/25, showed Res #5 voiced occasional anxiety and was unable to elaborate on the incident of inappropriate touching that had occurred the previous day. On 06/16/25 at 9:35 a.m., Res #5 was asked about the incident of inappropriate touching on 06/08/25. Res #5 was unable to recall the event or participate in the interview due to cognitive impairment. On 06/17/25 at 1:09 p.m., family member #1 stated Res #5 was not able to give consent to sexual advances due to cognitive impairment. They stated Res #5 would have been extremely upset and would have never allowed the inappropriate touching in the first place if they were in their right mind at the time of the incident. 2. An undated face sheet showed Res #4 had diagnoses which included schizoaffective disorder and bipolar disorder. An admission assessment, dated 06/05/25, showed Res #4 had a BIMS score of 15 and was cognitively intact. A resident interview statement, dated 06/09/25, showed Res #4 declined to comment on the incident with Res #5. A census tab in Res #4's medical record showed they were discharged from the facility on 06/09/25. On 06/17/25 at 1:00 p.m., certified nursing assistant #1 stated Res #5 never had a relationship or any interaction with Res #4 other than an occasional hello in the hallway prior to the incident. On 06/17/25 at 2:01 p.m., the ADON stated the ability to consent to sexual advances was based off a resident's intact decision-making ability. They stated Res #5 was severely cognitively impaired was not capable of consent. They stated Res #5 was touched inappropriately by Res #4.