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	09/10/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify a physician when a resident verbalized they would harm themself and others for 1 (#17) of 5 sampled residents reviewed for abuse and neglect.The DON identified 71 residents resided in the facility.Findings:An undated admission Record showed Resident #17 had diagnoses which included schizoaffective disorder bipolar type, other hallucinations, unspecified psychosis not due to a substance or known physiological condition, and unspecified depression.Resident #17's admission resident assessment, dated 08/19/25, showed the resident's cognition was intact with a BIMS of 14. The assessment showed the resident had hallucinations, delusions, and verbal behavioral symptoms directed towards others.A nursing note, dated 08/17/25 at 5:05 a.m., showed Resident #17 was at the nurses' station screaming and cussing, threatening to kill themself and others. The note showed the resident stated they were hearing voices and evil spirits and was very aggressive to staff. The note showed Resident #17 was put on one-on-one monitoring and 911 was called.There was no documentation the physician was notified.On 09/09/25 at 11:31 a.m., LPN #1 stated if a resident threatened to kill themself or others, they were to notify the psychiatric doctor, fill out an emergency order of detention form, initiate one-on-one monitoring, and send them to the emergency room.On 09/09/25 at 12:17 p.m., the ADON stated they were to notify the psychiatric provider if a resident threatened to kill themself or others.On 09/09/25 at 1:43 p.m., the ADON stated it did not appear the provider was notified about the incident on 08/17/25.

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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/03/25, a past noncompliance Immediate Jeopardy (IJ) was determined to exist related to resident-to-resident abuse.An incident report form, submitted to OSDH on 08/14/25, showed on approximately 06/21/25, Resident #2 pushed Resident #1 down on the bed, laid on top of them, and tried to kiss them several times.Based on record review and interview, the facility failed to ensure a resident was free from abuse for 1 (#1) of 3 sampled residents reviewed for abuse.The DON identified 71 residents resided in the facility.Findings:An undated facility policy titled Abuse Policy and Procedure, read in part, The administrator or Administrative Designee will conduct an investigation of all alleged or actual incidents of abuse, neglect, or misappropriation of property. The investigation should determine whether an incident has occurred, to what extent the resident was mistreated, by whom, and the measures needed to protect occupants from further incidents. If the person is able to communicate, the Administrator or Administrative designee shall document, in sufficient detail, the resident's account of the incident, including a description of the perpetrator.If a person alleges abuse, they should be assessed for mood and behavior changes that may indicate abuse, such as fear, isolation, depression, withdrawal, or other new signs. Findings will be documented in the medical record.An undated admission record showed Resident #1 had diagnoses which included anoxic brain damage, major depressive disorder, and anxiety disorder.A quarterly assessment, dated 06/24/25, showed Resident #1 was cognitively intact with a BIMS of 15. The assessment showed over the last two weeks Resident #1 had several days with little interest or pleasure in doing things and feeling down, depressed, or hopeless.An initial incident report, sent to OSDH on 08/14/25, showed an incident date of approximately 06/21/25. The report showed Resident #1 stated during an interview they had been sexually assaulted by Resident #2 approximately two months ago.A fax transmission report, dated 08/14/25 at 2:48 p. m., showed OSDH was sent a fax from the facility administrator.An incident note, dated 08/14/25, showed the nurse was informed Resident #1 made an allegation of abuse. The note showed Resident #1 stated they were held down on the bed by another resident and attempted to be kissed several times. The note showed local law enforcement, the physician, and physician assistant for mental health was notified. A police incident/offense report, dated 08/14/25, showed the local police was dispatched to the facility in reference to a possible sexual assault. The report showed Resident #1 stated they were in Resident #2's room sitting on the bed and Resident #2 was kissing them on the neck. The report showed Resident #1 could not leave the room because Resident #2 was lying on them. The report showed Resident #1 told Resident #2 their back was hurting and they left the room. The report showed Resident #1 stated they had told a staff member at the facility. The report showed the identified staff member was interviewed by police and they denied any knowledge of sexual assault between Resident #1 and Resident #2.A care plan, dated 08/14/25, showed Resident #1 was at risk for unwanted physical contact. The goal was for Resident #1 to remain safe from further unwanted contact.A facility in-service education report, dated 08/14/25, showed the administrator was educated on properly/thoroughly investigating abuse allegations.An untitled document, dated 08/14/25, showed six staff members were interviewed regarding knowledge of Resident #1's statement of rape and if Resident #2 was ever sexually inappropriate with any (resident of the opposite sex) in the facility.A record dated 08/14/25, read in part, Quality issue/problem. The record showed a meeting was conducted on 08/14/25 regarding resident-to-resident abuse.On 08/14/25 the facility completed a questionnaire with residents. The questionnaire asked if they had been sexually abused in the facility. Residents responded they had not been sexually assaulted in the facility. Resident #1 responded to the questionnaire they had been sexually assaulted by Resident #2 and had reported the incident to staff. A psychiatric exam report, dated 08/15/25, showed a psychiatric visit was completed for Resident #1 by the nurse practitioner. The report showed the visit was prompted by prior allegations made regarding a male peer entering their room. The report showed Resident #1 stated they and the peer of the opposite sex were friends. The report showed Resident #1 stated they did not feel threatened and enjoyed the attention the peer of the opposite sex gave them and valued their conversations.A facility in-service education report, dated 08/16/25, showed the facility staff were educated on Recognizing Indicators of Sexual Misconduct by a Resident.The administrator provided an untitled document, dated 08/20/25, that showed a referral was submitted to the abuse and neglect hotline regarding Resident #1's allegation of abuse by Resident #2.On 08/26/25 at 11:25 a.m., Resident #1 stated sometime in July, Resident #2 invited them to their room to play video games. Resident #1 stated Resident #2 pushed them down on the bed, positioned on top of them, and tried to kiss

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to prevent delay in care when Resident #11 was unresponsive.On [DATE] at 2:01 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On [DATE] at 2:07 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On [DATE] at 5:39 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,On [DATE], a review of all current residents' code status verified, and electronic records updated, and care plans updated. A list of all residents with current code status maintained at each nurse's station.All staff In-Serviced on calling 911 immediately when a resident is found unresponsive regardless of code status and resident code status list will be maintained at each nurse's station labeled Resident Code StatusAll Licensed nurses In-Serviced on immediately initiating CPR on any resident that is a full code and continuing until emergency services arrives.Any employee that can't be reached for In-Service will be inactive and taken off the schedule until education is provided.Completed by [DATE] 5 PM.The IJ was lifted, effective [DATE], when all components of the plan of removal had been verified as completed. Multiple staff on different shifts were interviewed regarding the in-service they received. Residents code status and care plan audit reviewed. Resident code status list placed at the nurse's station reviewed. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to prevent delay in care when a resident was unresponsive for 1 (#11) of 5 sampled residents reviewed for abuse and neglect.The DON identified 71 residents resided in the facility.Findings:An Emergency Procedure-Cardiopulmonary Resuscitation policy, revised 02/2018, read in part, If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR .If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR.Call 911.A care plan, initiated [DATE], showed Resident #11 had diagnoses which included unspecified dementia and Wernicke's encephalopathy. The care plan showed the resident was a full code and wished to have CPR performed on them. Resident #11's death in the facility resident assessment, dated [DATE], showed the resident was deceased .A nursing note, dated [DATE] at 4:43 a.m., read in part, This nurse was notified by CNA that resident did not appear to be breathing when CNA was performing last rounds. upon entering room [ROOM NUMBER] at 0443 [4:43 a.m.] Resident was found unresponsive. assessment revealed no respirations, no palpable carotid pulse and no heart or breath sounds on auscultation. resident is full code status CPR initiated and continued while other nurse called 911. EMT here and began to use AED but was unsuccessful Death was confirmed by EMT at 0521 [5:21 a.m.]. Dr. [name withheld], DON [name withheld], Administrator notified as well as family [name withheld]. body released to funeral home at 0703 [7:03 a.m.] [name withheld].An EMS Patient Care Record, dated [DATE], showed a primary impression as obvious death and secondary impression as cardiac arrest-withholding resuscitative efforts. The report showed the facility called them at 5:06 a.m. and they were on scene at 5:12 a.m. The report showed the facility did not start resuscitation efforts.On [DATE] at 11:40 a.m., the ADON stated all residents were full code unless they had a signed DNR on file. They stated a resident's code status would be in the electronic health record under the resident's name and on a list at the nurses station they implemented recently. They stated they were not sure when the list was implemented.On [DATE] at 11:45 a.m., the ADON stated if a resident was found unresponsive, the immediate action would be to get the crash cart, check code status, and begin CPR.On [DATE] at 11:46 a.m., the ADON stated staff were to notify EMS immediately.On [DATE] at 11:49 a.m., the ADON stated according to the nursing note on [DATE], the staff had performed CPR and notified EMS when the resident was found unresponsive. They stated anyone certified in CPR could perform CPR.On [DATE] at 11:51 a.m., the ADON stated they were not sure how Resident #11's code status was determined on [DATE].On [DATE] at 11:53 a.m., the ADON stated Resident #11's code status was not listed under their name in the electronic health record.On [DATE] at 3:38 p.m., CNA #3 stated a resident's code status would be located on their electronic health record. They stated they worked on [DATE] when Resident #11 was found unresponsive. CNA #3 stated they worked on a different hall and the agency nurse had instructed them to continue their rounds because CNA #2 and LPN #3 were with the resident.On [DATE] at 5:37 p.m., CNA #2 stated LPN #3 notified them they thought Resident #11 had passed and they were not sure what the resident's code status was because it was not listed under the

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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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 09/09/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide necessary care and treatment for Resident #17 who had mental health disorders and threatened to harm themself and others.On 09/09/25 at 2:14 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 09/09/25 at 2:27 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On 09/09/25 at 5:19 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,On 9/9/25, A review of all resident records was conducted to identify those with mental health disorders that may exhibit behaviors related to those disorders. All residents identified will have care plans updated to reflect mental health disorder/behavior. PCP and mental health will be aware of the identified residents to ensure all are evaluated and referred for services. To be completed by 9pm on 9/9/25All staff in-serviced that a current list of residents with mental health disorders is maintained at each nurse's desk. To be completed by 9pm on 9/9/25.All staff in-serviced that when a resident displays that he/she is a harm to themselves or others and to report behavior immediately to nurse supervisor/administrator. To be completed by 9pm on 9/9/25.Nursing staff will be in-serviced to notify the physician and mental health provider of the harmful behaviors immediately. To be completed by 9pm 9/9/25.The nursing staff will be in-serviced to request medication reconciliation with the physician and mental health provider following harmful/ mental health behaviors. To be completed by 9pm 9/9/25.Department supervisors are responsible for ensuring all in-services are completed by 9pm 9/9/25.Employees who are unable to be reached by 9pm on 9/9/25 will be required to in-service upon return to the facility.The IJ was lifted, effective 09/09/25, when all components of the plan of removal had been verified as completed. Multiple staff on different shifts were interviewed regarding the in-service they received. Resident audits for mental health disorders and behaviors were reviewed. A current list of residents with mental health disorders placed at the nurse's station was reviewed. Care plans for residents with mental health disorders and behaviors were reviewed. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to provide the necessary care and treatment for a resident with mental health disorders and behaviors for 1 (#17) of 5 sampled residents reviewed for abuse and neglect.The DON identified 71 residents resided in the facility. Findings:A facility assessment, dated 04/16/24, read in part, Manage the medical conditions and medication-related issues causing psychiatric symptoms and behaviors, identify and implement interventions to help support individuals with issues .care of individuals with depression, trauma/PTSD, other psychiatric diagnoses.An undated admission Record, showed Resident #17 had diagnoses which included schizoaffective disorder bipolar type, other hallucinations, unspecified psychosis not due to a substance or known physiological condition, and unspecified depression.A nursing note, dated 08/17/25 at 5:05 a.m., showed Resident #17 was at the nurses' station screaming and cussing, threatening to kill themself and others. The note showed the resident stated they were hearing voices and evil spirits and was very aggressive to staff. The note showed Resident #17 was put on one-on-one monitoring and 911 was called.A nursing note, dated 08/17/25 at 6:40 a.m., showed the police and emergency medical service refused to take Resident #17 to the emergency room.A care plan, initiated 08/18/25, showed Resident #17 would not harm themself or others. Resident #17's admission resident assessment, dated 08/19/25, showed the resident's cognition was intact with a BIMS of 14. The assessment showed the resident had hallucinations, delusions, and verbal behavioral symptoms directed towards others. The assessment showed the resident received antipsychotic, antianxiety, and antidepressant medications.A nursing note, dated 08/26/25 at 4:01 p.m., showed Resident #17 had conversations with themself. The note showed the resident stated their medications made them crazy. The nursing note showed the physician was notified.There was no documentation the resident was evaluated by a psych provider or had a medication reconciliation after the incident.A nursing note, dated 09/06/25 at 4:17 a.m., showed Resident #17 was cussing, being loud and aggressive. The note showed a nurse attempted to calm the Resident #17 and the resident shoved the nurse into the wall and was holding them against the wall. Resident #9 came to intervene and was held by the arm and neck and pushed onto the sofa by Resident #17. The note showed staff separated the residents. A nursing note, dated 09/06/25 at 6:50 a.m., read in part, Resident #17 received an immediate discharge from the facility due to violently attacking the staff and choking another resident An Initial State Reportable