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	11/18/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	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 protect residents from physical abuse for 3 (#1, 2, and #4) of 3 sampled residents reviewed for abuse.The administrator identified 59 residents resided in the facility. Findings: An undated facility Abuse Prevention Program policy, read in part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but not limited to freedom from verbal, mental, sexual or physical abuse. 1. A nurse's note, dated 10/24/25 at 12:40 p.m., read in part, Noise was heard from this resident room, when approached door, [Resident #3] coming out of room. [Resident #4)] reported that [they] was in [their] room and all of a sudden the [Resident #3] came in and then started waving arms around and cussing. [Resident #3] then made contact with their left arm, resulting in small bruise to left forearm. [Resident #3] taken back to room. Call placed to [name withheld] Police department, Admin [administrator] notified. No family listed to notify. Also notified ADON [assistant director of nursing]. [Resident #3] to be moved to front of building, currently placed on 1:1. An Initial State Reportable Incident form, dated 10/24/25, showed physical harm. The form showed Resident #3 entered Resident #4's room and began waving their arms and cussing. The form showed Resident #3 made physical contact with Resident #4's arm resulting in a small bruise to their left arm. Resident #4's quarterly resident assessment, dated 10/28/25, showed the resident's cognition was intact with a BIMS of 15. The assessment showed the resident had diagnoses which included depression, schizophrenia, and bipolar disorder. The assessment showed the resident was ambulatory and independent in most activities of daily living. On 11/17/25 at 4:00 p.m., Resident #4 stated Resident #3 went into their room. They stated they informed Resident #3 they were in the wrong room and Resident #3 hit them twice on their left arm. They stated it resulted in a bruised. On 11/18/25 at 11:05 a.m., LPN #1 stated Resident #4 reported to them Resident #3 stroked them on their arm when they informed Resident #3 to get out of their room. On 11/18/25 at 11:08 a.m., LPN #1 stated the incident between Resident #3 and Resident #4 could be considered physical abuse. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #1's care plan, revised 9/17/25, showed the resident had limited physical mobility related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Resident #1's significant change in status resident assessment, dated 10/22/25, showed the resident's cognition was intact with a BIMS of 14. The assessment showed the resident had diagnoses which included hemiplegia or hemiparesis and anxiety. The assessment showed the resident needed partial to moderate assistance with most activities of daily living. A nurse's note, dated 11/03/25 at 12:10 p.m., read in part, This nurse [LPN #2] was in the dining room when I heard screaming. [CNA #1] arrived at the [Resident #1] first. [CNA #1] stated, 'When they walked in, they were swinging on each other.' When [LPN #2] arrived, residents had been separated. When [LPN #2] ask [Resident #1] what happened, the resident stated, '[Resident #3] came in my room. I turned around and put my hand out to stop [them] and [Resident #3] started hitting me.' Head to assessment complete .Resident has a ST [small tear] on LT [left] arm.2.5x1x0.1. An Initial State Reportable Incident form, dated 11/03/25, showed certain injuries. The form showed Resident #3 roamed the hallway and diverted into Resident #1's room. The form showed Resident #1 attempted to redirect Resident #3, it was unsuccessful and the residents had a physical altercation. On 11/18/25 at 9:17 a.m., LPN #2 stated Resident #3 was blind. They stated the resident got away from them and roamed into Resident #1's room. They stated by the time they made it to Resident #1's room, the residents were already separated. On 11/18/25 at 9:42 a.m., CNA #2 stated they heard Resident #1 and Resident #3 getting loud. They stated by the time they made it to Resident #1's room, Resident #1 was holding on to Resident #3's shirt. They stated Resident #3 was swinging at Resident #1 making physical contact. On 11/18/25 at 10:52 a.m., Resident #1 stated Resident #3 came into their room. They stated they told the resident to get out of their room twice and they did not. Resident #1 stated they tried to push Resident #3 out using their wheelchair and the resident swung at them hitting them. 3. On 11/17/25 at 3:52 p.m., Resident #2 was observed sitting in the dining room visiting with another resident. On 11/18/25 at 8:50 a.m., Resident #2 was observed in their room on their bed. An annual assessment, dated 08/19/25, showed Resident #2 had a BIMS score of 11, which indicated the resident was moderately impaired in cognition for daily decision making, and had a diagnoses of Alzheimer's disease and schizophrenia. A care plan, dated 08/28/25, showed Resident #2 had the potential to be physically and verbally aggressive related to Alzheimer's disease and schizophrenia. A state report, with an incident date of 11/04/25, showed Resident #3 was in the dining room requesting coffee and had wheeled over to Resident #2. The report showed Resident #2 had become verbally loud and staff separated the residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse progress note, dated 11/17/25 at 4:02 p.m., showed Resident #2 and Resident #3 were observed arguing in the dining room. The note showed Resident #2 was hit on the right side of their head during the altercation and the residents were separated. The note showed there were no visible injuries to Resident #2. On 11/18/25 at 8:53 a.m., LPN #1 stated on 11/04/25, Resident #2 and Resident #3 had been involved in a verbal altercation in the dining room and Resident #3 hit Resident #2 on the right side of their head. They stated the residents were separated and Resident #2 had been assessed for injuries. On 11/18/25 at 8:59 p.m., LPN #2 stated after the incident, Resident #3 was placed on 1:1 with staff until they were sent to the hospital for in-patient psychiatric treatment. LPN #2 stated Resident #2 had been assessed for injuries related to being hit in the head by their assigned nurse. On 11/18/25 at 9:55 a.m., the administrator stated Resident #2 and Resident #3 had been involved in a resident-to-resident abuse incident on 11/04/25. They stated Resident #3 had been placed on 1:1 with staff until they had been admitted to the hospital for in-patient psychiatric services. They stated Resident #2 had not sustained injuries from the altercation.

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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. Based on record review and interview, the facility failed to ensure:a. an abuse allegation was reported to the State Agency within two hours for 1 (#1); andb. a final report was submitted to the State Agency within five business days for 3 (#1, 2 and #3) of 3 sampled residents reviewed for abuse.The administrator identified 59 residents resided in the facility. Findings: An undated facility Abuse Prevention Program policy, read in part, When the allegation involves abuse or results in serious bodily injury you must report within 2 hours of notification of incident .The Administrator or Administrative Designee will complete the Investigation Report within five (5) working days .The investigation Report . shall be faxed within five (5) working days of submission of the incident and accident report. 1. A nurse's note, dated 11/3/25 at 12:10 p.m., read in part, This nurse [LPN #2] was in the dining room when I heard screaming. [CNA #1] arrived at the [Resident #1] first. [CNA #1] stated, 'When they walked in, they were swinging on each other.' When [LPN #2] arrived, residents had been separated. When [LPN #2] ask [Resident #1] what happened, the resident stated, '[Resident #3] came in my room. I turned around and put my hand out to stop [them] and [Resident #3] started hitting me.' Head to assessment complete . Resident has a ST [small tear] on LT [left] arm.2.5x1x0.1. An Initial State Reportable Incident form, received 11/03/25 at 3:22 p.m., showed certain injuries. The form showed Resident #3 roamed the hallway and diverted into Resident #1's room. The form showed Resident #1 attempted to redirect Resident #3, it was unsuccessful and the residents had a physical altercation. The initial state reportable was not submitted within 2 hours of the incident which occurred on 11/03/25 at 12:10 p.m. There was no documentation the State Agency received a final report. On 11/18/25 at 9:17 a.m., LPN #2 stated the incident occurred on 11/03/25 at 12:10 p.m. On 11/18/25 at 9:19 a.m., LPN #2 stated they notified the administrator at the time of the incident. On 11/18/25 at 9:31 a.m., the compliant and incident coordinator for the State Agency stated the State did not receive a final report on Resident #1 and Resident #3. On 11/18/25 at 9:50 a.m., the administrator stated timely reporting of abuse allegations to the State was two hours. On 11/18/25 at 9:51 a.m., the administrator stated they were not sure of the exact time, but pretty sure they were notified immediately of the incident between Resident #1 and Resident #3. They stated they would have to look at the nurse's notes. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/25 at 9:54 a.m., the administrator stated they would have to look at the incident report to know when they submitted the final report to the State. They stated the timeframe to submit a final report was five business days. On 11/18/25 at 2:09 p.m., the administrator reviewed the facility's fax machine logs. They stated the initial was submitted at 3:36 p.m. on 11/03/25 and the final was sent in on 11/07/25 at 4:21 p.m. On 11/18/25 at 2:13 p.m., the administrator stated if the incident between Resident #1 and Resident #3 occurred at 12:10 p.m., then the report was not submitted in a timely manner. On 11/18/25 at 2:32 p.m., the administrator stated they were notified of the incident at 2:30 p.m. On 11/18/25 at 2:35 p.m., the administrator stated the incident between Resident #1 and Resident #3 was resident to resident abuse. On 11/18/25 at 2:36 p.m., the administrator stated there must be a miscommunication on when the incident between Resident #1 and Resident #3 occurred. 2. A state report, with an incident date of 11/04/25, showed Resident #3 was in the dining room requesting coffee and had wheeled over to Resident #2. The report showed Resident #2 had become verbally loud and staff separated the residents. The incident report form showed it was an initial and final report with an attached fax transmission report dated 11/04/25 at 5:26 p.m. On 11/18/25 a review of incident reports, in the State Agency's data base, was conducted. The data base did not show a final incident report for the incident on 11/04/25 for Resident #2 and Resident #3. A fax transmission log, dated 11/18/25, provided by the administrator showed a fax had been sent to the State Agency's fax number on 11/10/25 with a code NG beside the transmission. On 11/18/25 at 9:55 a.m., the administrator stated the fax transmission report, dated 11/04/25 at 5:26 p.m. was for the initial state report. The administrator stated they had check marked final on the incident report form, completed part C, and faxed it to the state agency on 11/10/25. The administrator stated they did not have a fax confirmation for the final incident report. On 11/18/25 at 4:33 p.m., the administrator stated the code NG indicated the communication between the facility's fax machine and the state agency's fax machine had not been transmitted successfully. They stated when faxes were successfully transmitted the code on the log would show OK.