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	03/05/2026

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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 02/25/26, an IJ situation was determined to exist related to the facility's failure to ensure controlled medications were not misappropriated for Res #2 and Res #6.On 02/26/26 at 11:25 am., the Oklahoma State Department of Health verified the existence of an IJ situation.On 02/26/26 at 11:57 a.m., the administrator was notified of the IJ situation and an IJ template was provided.On 03/03/26 at 2:02 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility's plan of removal showed a full audit of all controlled substances (all units and all shifts) was completed immediately by the on-sight nurse consultant. Law enforcement and physician were notified. The administrator was educated by the corporate administrator on policies and procedures to prohibit/prevent any misappropriation of controlled medications, investigate any allegations, and report any allegations to the Oklahoma State Department of Health and law enforcement.The plan of removal showed the licensed nurses and CMAs were in-serviced, in person or by phone, by the administrator, they would be responsible for accepting medications from the pharmacy and signing verification of what was delivered. All licensed nurses and CMAs were in-serviced to properly log controlled medications on the narcotic count sheets, checking/documenting on the MAR when administered, verifying count was correct at shift change, and narcotic count sheets that were completed will be given to the DON with any discrepancies reported to the administrator immediately. In-serviced by phone/in-person by the administrator by 3:00 p.m. on 02/26/26.The plan of removal showed all licensed nurses and CMAs educated by administrator and ADON on turning in all medication receipts from the pharmacy, completed narcotic count sheets, and any other drug records into the DON immediately. The facility's plan of removal, read in part, All licensed nurses and CMAs will be re-educated by the pharmacy consultant on controlled substance regulations and drug diversion. The ADON will educate on proper narcotic count procedures, documentation requirements, chain-of-custody, identifying and reporting drug diversion, reporting requirements for unusual occurrences, steps required when a discrepancy is found, and consequences of noncompliance will be completed by 5:00 p.m. on 03/04/26.The IJ was lifted, effective 03/04/26 at 5:00 p.m., when all components of the plan of removal had been completed. All in-services and training reviewed. Staff interviews regarding misappropriation of controlled medications had been completed. The deficiency remained at a pattern with the potential for more than minimum harm.Based on record review and interview, the facility failed to ensure controlled medications were not misappropriated for 2 (#2 and #6) of 5 sampled residents reviewed for misappropriation.The ADON identified 21 residents with controlled medications resided in the facility. Findings: An undated policy titled Abuse Policy and Procedure, read in part, It recognizes resident rights to be free.from misappropriation of resident property.1. An undated diagnoses list showed Res #6 was admitted to the facility on [DATE] with diagnoses which included chronic pain, hypertension, and major depressive disorder.A pharmacy packing slip for Res #6, dated 12/15/25, showed 120 oxycodone/APAP (opioid/non-opioid) were delivered for Res #6. There were no documentation, narcotic count sheets or medication logs, to account for 90 of the 120 tablets delivered on 12/15/25.A physician's order for Res #6, dated 12/24/25, showed oxycodone/APAP 10-325mg, one tablet every six hours as needed. The physician's (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	order showed the order was discontinued on 01/30/26.A multi-dated Medication Log of Receiving form for Res #6 did not show the oxycodone/APAP was logged as being delivered on 12/15/25.A MAR for Res #6, dated 12/2025 and 01/2026, showed three doses were administered on 12/27/25, 12/31/25, and 01/05/26.A controlled drug count sheet for Res #6, with a received date of 12/15/25, showed 30 oxycodone/APAP 10-325 mg were received. The form showed an additional 19 doses were administered which were not documented on the MAR.On 02/20/26 at 11:45 a.m., CMA #1 stated their name had been forged on the count sheet on multiple days. CMA #1 stated Res #6 never asked for pain medication and the only dose they took was the first dose. CMA #1 stated Res #6 said they did not like the way it made him feel. CMA #1 stated they informed the administrator and were told it would be taken care of.On 02/24/26 at 9:25 a.m., Res #6 stated they had not taken the oxycodone/APAP because they did not like the way it made them feel. Res #6 stated the last time they took the pain medication was about two months ago.On 02/24/26 at 10:48 a.m., LPN #1 stated CMA #1 had told them about the narcotic count sheet and advised CMA #1 to report it to the administrator.On 02/24/26 at 2:50 p.m., CMA #2 stated the issue was found during a count of the medication cart on 01/16/26. CMA #2 stated CMA #1 immediately went to the administrator to report it.On 02/24/26 at 3:42 p.m., the administrator stated they were never informed about the issue with the count sheet for Res #6.On 02/25/26 at 11:34 a.m., LPN #1 stated they did not feel like it was their place to follow up because the DON was usually responsible for that.On 02/25/26 at 11:46 a.m., the ADON stated they only made sure the count on the sheet and the card matched, then it went into lock up in the DON's office. The ADON stated it was usually the RN's responsibility to perform the medication reconciliation.On 02/25/26 at 12:09 p.m., the administrator stated it should be the RN or the charge nurse who reconciled the count sheet with the medication administration record. They stated it would be the DON going forward.On 02/25/26 at 12:35 p.m., LPN #2 stated they did not administer Res #6 any narcotics and they did not sign the count sheet.On 02/25/26 at 2:20 p.m., pharmacy staff confirmed 120 oxycodone/APAP (opioid/non-opioid) 10-325mg were delivered to the facility on [DATE] for Res #6.On 02/26/25 at 8:45 a.m., an anonymous staff member stated they witnessed CMA #1 report to the administrator and ADON that someone signed their name on the narcotic count sheet. 2. An undated diagnoses list showed Res #2 admitted to the facility with diagnoses which included chronic pain and major depressive disorder.A physician's order for Res #2, dated 09/21/25, showed hydrocodone/APAP 7.5-325 mg, one tablet by mouth three times a day.A pharmacy packing slip for Res #2, dated 01/08/26, showed 90 hydrocodone/APAP 7.5-325 mg were delivered to Res #2. There was no documentation to account for 30 of the 90 tablets delivered on 01/08/26.A multi-dated Medication Log of Receiving form for Res #2 did not show the hydrocodone/APAP 7.5-325 mg 90 were logged in.An interview with pharmacy staff confirmed #90 Hydrocodone/APAP 7.5-325 mg 90 were delivered to the facility on [DATE] for Res #2.On 02/27/26 at 2:55 p.m., Res #2's controlled drug count sheets for 11/2025, 12/2025, 01/2026, and 02/2026 with packing slips from the pharmacy were reconciled with the ADON. The count showed 30 hydrocodone/APAP 7.5-325 mg were unaccounted for. The ADON stated there should have been three count sheets for 01/2026 and they only located two.On 02/27/26 at 3:00 p.m., the DON stated they went through all the medications in lock up and the missing medications for Res #2 could not be located.

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 02/25/26 at 3:03 p.m., an IJ situation was determined to exist related to the facility's failure to implement written policies and procedures for reporting, prohibiting, and preventing the misappropriation of Res #6's controlled narcotic medications.On 02/26/26 at 11:46 a.m., the Oklahoma State Department of Health verified the existence of an IJ situation.On 02/26/26 at 12:05 p.m., the administrator was notified of the IJ situation and provided the IJ template. On 03/03/26 at 2:02 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility plan of removal showed the administrator was educated on policies and procedures that prohibited/prevented any misappropriation of controlled medications, investigated any allegations, and reported any allegations to the Oklahoma State Department of Health and law enforcement by the corporate administrator.The plan of removal showed all licensed nurses and CMAs would be re-educated by 3:00 p.m. on 03/04/26 by the corporate administrator, ADON, and LPN #4 on reporting requirements, controlled substance chain of command, and documentation requirements.The IJ was lifted, effective 03/04/26 at 3:00 p.m., when all components of the plan of removal had been completed. All in-services in the plan of removal were reviewed, and staff interviews were conducted regarding implementing policies/procedures and reporting/investigating allegations of misappropriation of controlled narcotic medications had been completed. The deficiency remained at a pattern with the potential for more than minimum harm. Based on record review and interview, the facility failed to:a. implement policies and procedures for misappropriation of a resident's controlled narcotic medications; andb. implement the policy for report and investigate allegations of misappropriation of controlled narcotic medications for 1 (#6) of 7 sampled residents reviewed for reporting misappropriation of controlled medications.The ADON identified 21 residents in the facility received controlled narcotic medications. Findings:An undated Abuse Policy and Procedure, read in part, It recognizes resident rights to be free from misappropriation of resident property .The administrator will immediately report the allegation to the Oklahoma State Department of Health and the local police. The administrator or administrative designee will conduct an immediate investigation of all alleged misappropriation of property.An undated diagnoses list showed Res #6 was admitted to the facility on [DATE] with diagnoses which included chronic pain, hypertension, and major depressive disorder.A pharmacy packing slip for Res #6, dated 12/15/25, showed 120 oxycodone/APAP were delivered for Res #6. There was no documentation to account for 90 of the 120 tablets delivered on 12/15/25.A physician's order for Res #6, dated 12/24/25, showed oxycodone/APAP (an opioid/non-opioid) 10-325mg, one tablet every six hours as needed. The physician's order showed the order was discontinued on 01/30/26.A multi-dated Medication Log of Receiving form for Res #6 did not log the oxycodone/APAP that was delivered on 12/15/25.A MAR for Res #6, dated 12/2025 and 01/2026, showed three doses were administered on 12/26/25, 12/31/25, and 01/05/26.A controlled drug count sheet for Res #6, with a received date of 12/15/25, showed 30 oxycodone/APAP 10-325mg were received. The form showed an additional 19 doses were administered that were not documented on the 01/2026 MAR.On 02/20/26 at 11:45 a.m., CMA #1 stated their name had been forged on the count sheet on multiple days. CMA #1 stated Res #6 never asked for pain medication and the only dose they took was the first dose. They stated Res #6 stated they did not like the way it made them feel. CMA #1 stated they informed the administrator and were told it would be taken care of.On 02/24/26 at 9:25 a.m., Res #6 stated they had not taken the oxycodone/APAP because they did not like the way it made them feel. Res #6 stated the last time they took the pain medication was about two months ago.On 02/24/26 at 10:48 a.m., LPN #1 stated CMA #1 had told them about the narcotic count sheet and advised CMA #1 to report it to the administrator.On 02/24/26 at 2:50 p.m., CMA #2 stated the issue was found during a count of the medication cart on 01/16/26. CMA #2 stated CMA #1 immediately went to the administrator to report (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	it.On 02/24/26 at 3:42 p.m., the administrator stated they were never informed about the issue with the narcotic count sheet for Res #6 and the OSDH and law enforcement were not notified.On 02/25/26 at 11:34 a.m., LPN #1 stated they did not feel like it was their place to follow up because the DON was usually responsible for that.On 02/25/26 at 11:46 a.m., the ADON stated they only made sure the count on the sheet and the card matched then it went into lock up in the DON's office. The ADON stated it was usually the RN's responsibility to perform the medication reconciliation.On 02/25/26 at 12:09 p.m., the administrator stated it should be the RN or charge nurse reconciling the count sheet with the MAR record. The administrator stated it would be the DON going forward.On 02/25/26 at 12:35 p.m., LPN #2 stated they did not administer Res #6 any narcotic and they did not sign the count sheet.On 02/25/26 at 2:20 p.m., phone interview with pharmacy staff confirmed 120 oxycodone/APAP 10-325mg were delivered to the facility on [DATE] for Res #6.On 02/26/25 at 8:45 a.m., an anonymous staff member stated they witnessed CMA #1 report to the administrator and ADON that someone signed their name on the narcotic count sheet.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an immediate written notice of discharge was provided to a hospital upon transfer for 1 (#24) of 2 sampled residents reviewed for unplanned discharges.The administrator identified 17 residents had been discharged in the last 30 days. Findings:An Emergency Transfer or Discharge policy, dated 08/2023, read in part, Emergency transfers or discharge may be necessary to protect the health and/or well-being of the resident(s).Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: notify the receiving facility that the transfer is being made.prepare a transfer form to send with the resident.others as appropriate or as necessary.A medical diagnosis sheet for Res #24, dated 02/05/26, showed the resident was admitted with diagnoses which included traumatic brain injury with loss of consciousness and mood disorder.An admission assessment for Res #24, dated 02/05/26, showed the resident was awake, alert, and oriented to person, place, time, and situation. The assessment showed the resident rejected care and had physical and verbal behaviors.A BIMS evaluation for Res #24, dated 02/06/26, showed the resident was cognitively intact with a BIMS score of 14. Nurse notes for Res #24, dated 02/06/26, showed the resident had been upset most of the shift and was yelling and cursing at facility staff with continued requests to be discharged from the facility. The notes showed Res #24 was placed on one on one monitoring and then continued to yell, curse, hoard medications, and attempted to throw themself onto the floor from the bed. The notes showed Res #24 attempted to hit staff members and threatened with suicide if they were not allowed to leave the facility. An immediate discharge written notice for Res #24, dated 02/06/26 at 10:30 p.m., showed the facility's intent to discharge Res #24 from the facility. The notice showed Res #24's drastic violent episodes endangered the health and safety of others in the facility. The notice showed Res #24 required police intervention for removal from the facility for the attempted assault on staff.A police report, dated 02/06/26, showed an officer was dispatched to the facility due to a resident threatening staff, damaging property, and making threats of suicide. The report showed Res #24 reiterated their plan of self-harm and desire to leave the facility to the responding officer. The note showed the police officer transported Res #24 to the hospital for further evaluation per Res #24's request.On 02/18/26 at 3:00 p.m., the administrator stated Res #24 was provided with an immediate written discharge notice prior to leaving the facility with the police because their presence endangered the safety and health of others in the facility. They stated Res #24 requested to be discharged repeatedly during their stay in the facility. On 02/19/26 at 9:04 a.m., LPN #1 stated they provided Res #24 with the immediate written discharge notice on 02/06/26. LPN #1 stated having explained the contents of the letter to Res #24 prior to handing the notice to them. LPN #1 stated Res #24 then threw the notice on the ground and stated they did not care about the notice as long as they were able to leave the facility and not have to come back. On 02/20/26 at 9:40 a.m., the administrator stated a hospital case manager contacted them on 02/08/26 and stated Res #24 would be discharged back to the facility. They stated the case manager was made aware Res #24 had been discharged from the facility prior to leaving with the police officer on 02/06/26. The administrator stated the police officer had been made aware Res #24 was discharged from the facility and they assumed all medical transfer forms which included the immediate discharge notice had been sent with the resident to the hospital.On 02/20/26 at 2:09 p.m., LPN #2 stated they had discharged Res #24. They stated a face sheet, medical diagnosis list, and list of medications were sent with the resident. LPN #2 stated they did not send a copy of the immediate discharge notice with the other transfer documentation.On 02/23/26 at 9:30 a.m., the administrator stated the nurse should have sent the immediate discharge notice with Res #24 to ensure the receiving facility knew the resident had been discharged from the facility.On 02/23/26 at (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:33 a.m., the medical director stated Res #24 had become a threat to themself and others which necessitated an emergency discharge. They stated they agreed with the discharge and felt the resident was inappropriate to live in the facility. The medical director stated the immediate notice of discharge should have been sent with the resident to ensure the receiving facility was aware of the situation. On 02/23/26 at 1:30 p.m., the hospital case manager stated the hospital did not receive a copy of the resident's immediate discharge notice until they contacted the facility in an attempt to discharge Res #24 back to the facility on [DATE]. The hospital case manager stated Res #24 remained in the hospital at this time.

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 02/25/26, an IJ situation was determined to exist related to the facility's failure to ensure a system was in place to reconcile controlled narcotic medications to prevent misappropriation of Res #2 and Res #6 controlled narcotic medications.On 02/26/26 at 3:24 p.m., the Oklahoma State Department of Health verified the existence of an IJ situation.On 02/26/26 at 3:46 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On 03/04/26 at 2:13 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility's plan of removal showed on 02/27/26 the administrator and DON were in-serviced by the corporate administrator regarding the facility's controlled-substance reconciliation system. The in-service included mandatory reporting and record keeping requirements.The plan of removal showed effective 02/26/26, all narcotic deliveries received would be verified against the pharmacy delivery receipt and signed into the controlledˆdrug count sheets by a licensed nurse at the time of receipt. Delivery receipts were attached to the unit's narcotic packet and routed to the DON by end of shift.The plan of removal showed on 02/26/26 through 02/27/26 the nurse consultant completed a fullˆscope audit of all units and verified medication availability for all residents with active orders. No current stock discrepancies affecting resident care were identified. Access to controlled substances were immediately restricted to licensed nurses only. CMAs would no longer receive or administer controlled substances. On 02/26/26, the medication storage for controlled substances was verified as doubleˆlocked and functional, and end of shift dual signature counts by two licensed nurses were implemented.The plan of removal showed all licensed nurses and CMAs were reˆeducated by the ADON and LPN #4 on reconciliation, documentation, chain of custody, discrepancy escalation, and reporting expectations. This was to be completed by 5:00pm 03/04/26.The IJ was lifted, effective 03/04/26 at 5:00 p.m., when all components of the plan of removal had been completed. All in-services and training was reviewed. Staff interviews regarding reconciliation, documentation, chain of custody, discrepancy escalation, and reporting expectations of controlled narcotic medications. The deficiency remained at a pattern with the potential for more than minimum harm.Based on record review and interview, the facility failed to ensure a system was in place for receipt, disposition, and reconciliation of controlled narcotic medications for 2 (#2 and #6) of 7 sampled residents reviewed for misappropriation of medications.The administrator identified 21 residents with controlled narcotic medications resided in the facility. Findings: An undated Controlled Substance (Narcotic) Counting and Accountability Policy, read in part, The facility shall maintain a system for the receipt, storage, administration, counting, reconciliation, investigation of discrepancies, and destruction of all controlled substances. Upon delivery from pharmacy, two authorized staff members shall verify medication name, strength, quantity, and resident name, Initial count shall be documented and signed. 1. An undated diagnoses list showed Res #6 was admitted to the facility on [DATE] with diagnoses which included chronic pain, hypertension, and major depressive disorder. A pharmacy packing slip for Res #6, dated 12/15/25, showed 120 oxycodone/APAP were delivered for Res #6. Count sheets and medication cards for 90 tablets were unable to be located.A controlled drug count sheet for Res #6, with a received date of 12/15/25, showed 30 oxycodone/APAP 10-325mg were received. The form showed an additional 19 doses were administered that were not documented on the MAR as administered to the resident.A physician's order for Res #6, dated 12/24/25, showed oxycodone/APAP (an opioid/a non-opioid) 10-325mg, one tablet every six hours as needed. The physician's order showed the order was discontinued on 01/30/26.A multi-dated facility Medication Log of Receiving form for Res #6 did not log the oxycodone/APAP that was delivered on 12/15/25.A MAR for Res #6, dated 12/2025 and 01/2026, showed three doses were administered 12/27/25, 12/31/25, and 01/05/26.On 02/20/26 at 11:45 a.m., CMA #1 stated their name had been forged on the (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	count sheet on multiple days. CMA #1 stated the resident never asked for pain medication and the only dose Res #6 took was the first one. CMA #1 stated Res #6 did not like the way it made them feel. CMA #1 stated they informed the administrator and was told it would be taken care of.On 02/24/26 at 9:25 a.m., Res #6 stated they had not taken the oxycodone/APAP because they did not like the way it made them feel. Res #6 stated the last time they took the pain medication was about two months ago.On 02/24/26 at 12:58 p.m., the administrator stated the facility was without a full-time DON from 12/02/25 through 02/09/26.On 02/24/26 at 2:50 p.m., CMA #2 stated the issue was found during a count of the medication cart with CMA #1. CMA #2 stated CMA #1 immediately went to the administrator to report it.On 02/25/26 at 11:46 a.m., the ADON stated they only made sure the count on the sheet and the card matched, then it went into lock up in the DON's office. The ADON stated it was usually the RN's responsibility to perform the medication reconciliation.On 02/25/26 at 12:09 p.m., the administrator stated it should be the RN or charge nurse who reconciled the count sheet with the MAR. They stated it would be the DON going forward.On 02/25/26 at 12:35 p.m., LPN #2 stated they did not administer Res #6 any narcotics and they did not sign the count sheet.On 02/25/26 at 2:20 p.m., pharmacy staff confirmed 120 oxycodone/APAP 10-325mg were delivered to the facility on [DATE] for Res #6.On 02/26/25 at 8:45 a.m., an anonymous staff member they stated they witnessed CMA #1 report to the administrator and ADON that someone signed their name on the narcotic count sheet. 2. An undated diagnoses list showed Res #2 admitted to the facility with diagnoses which included chronic pain and major depressive disorder.A physician's order for Res #2, dated 09/21/25, showed hydrocodone/APAP 7.5-325 mg, one tablet by mouth three times a day.A pharmacy packing slip for Res #2, dated 01/08/26, showed 90 hydrocodone/APAP 7.5-325 mg were delivered to Res #2. A count sheet and a medication card for 30 tablets were unable to be located.A multi-dated Medication Log of Receiving form for Res #2 did not show the hydrocodone/APAP 7.5-325 mg 90 were logged in.On 02/24/26 at 12:58 p.m., the administrator stated the facility was without a full time DON from 12/02/25 through 02/09/26.On 02/27/26 at 10:30 a.m., pharmacy staff confirmed 90 hydrocodone/APAP 7.5-325 mg 90 were delivered to the facility on [DATE] for Res #2.On 02/27/26 at 2:55 p.m., Res #2's controlled drug count sheets for 11/2025, 12/2025, 01/2026, and 02/2026 with the packing slips from the pharmacy were reconciled with the ADON. The reconciliation showed 30 hydrocodone/APAP 7.5-325 mg were unaccounted for. The ADON stated there should have been three count sheets for 01/2026 and they located two.

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	03/05/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a clinical rationale from the physician was provided on a gradual dose reduction request for an antipsychotic and an antidepressant medication for 1 (#30) of 6 sampled residents reviewed for unnecessary medications. The ADON identified 47 residents received psychotropic medications. Findings: An undated facility policy titled Gradual Dose Reduction (GDR) Policy-Oklahoma Nursing Facility, read in part, To ensure residents prescribed psychotropic medications receive appropriate gradual dose reductions and non-pharmacologic interventions consistent with CMS guidance. The physician will document a rationale if contraindicated. Res #30's admission record dated 10/16/23, showed the resident was admitted on [DATE] with diagnoses which included paranoid schizophrenia, chronic pain, restless leg syndrome, paraplegia, major depressive disorder, obsessive compulsive disorder, hypertension, catheter status, and anxiety. A quarterly MDS assessment for Res #30, dated 12/16/25, showed the resident had a BIMS score of 15 which indicated intact cognition. Medications included:D-Mannose 500mg (2) caps twice daily, for urinary tract support,NAC 600mg twice daily, decrease liver damage,Depakote 500mg twice daily, for behavior management,Trazodone 150mg daily, for sleep, Trintellix 20mg daily, to treat major depressive disorder, Desvenlafaxine 50mg daily, to treat depression,Meloxicam 15mg daily, for arthritis, Olanzapine 5mg daily, antipsychotic used to treat schizophreniaFesoterodine 8mg daily, used to treat neurogenic bladder, Quetiapine 300mg daily, used to treat schizophrenia, and PRN hydrocodone (pain relief), milk of magnesia (constipation), ibuprofen (pain), tylenol (pain), narcan (opioid overdose), and zofran (nausea) A GDR request by pharmacy consultant, on 12/31/25, showed the physician declined the GDR request but did not document the rationale. A Medication Regimen Review dated 12/31/25, read in part, please consider if appropriate, a reduction of one of these agents:Quetiapine 300mg at bedtime (4-2024)Trintellix 20mg daily was added (8-2024) Is a reduction attempt in Quetiapine to 250mg at bedtime appropriate?A line was checked no, a reduction is contraindicated due to:, but no rationale was documented in the space provided. Is a reduction attempt in Trintellix 20mg daily appropriate? The physician had checked no, a reduction is contraindicated due to:, but no rationale was documented in the space provided On 03/02/26 at 3:24 p.m., the ADON verified the GDR request for Quetiapine and Trintellix was signed by the physician who declined a dose reduction request, but no rationale was documented. They verified the GDR request was noted by a nurse and there was no documentation asking the physician about a rationale for declining dose reduction request.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain an effective pest control program.The administrator identified 61 residents resided in the facility. Findings: On 02/17/26 at 10:30 a.m., a tour of the kitchen and dining room was conducted. The following observations were made:a. a pile of mouse droppings mixed with chewed wall particles were observed on the floor under the dishwasher,b. dead roaches were observed along the baseboards in the kitchen and dining room and inside the ice machine, andc. live roaches were observed crawling on the floor and walls around the tables storing coffee cups and the ice machine. On 02/18/26 at 9:20 a.m., the following was observed in Resident #6's room:a. dead roaches and mouse droppings were on the floor and sticky traps in the closets and bathroom, and b. a live roach was crawling in the room refrigerator. On 02/24/26 8:30 a.m., live roaches were observed around ice machine and on the walls and floors in the dining room. An undated facility policy titled Pest Control, read in part, This facility maintains an on-going pest control program to ensure their building is kept free of insects and rodents. Resident #6's admission record showed resident was admitted on [DATE] with diagnoses which included dysphagia, hemiplegia, sequelae of cerebral infarction, chronic pain syndrome, supra pubic catheter status, and open wound of buttocks. A 5-day MDS assessment for Res #6, dated 02/04/26, showed the resident had a BIMS score of 15 indicating intact cognition. A care plan for Res #6, updated 02/06/26, showed the resident was bed/chair bound and required moderate assistance with all activities of daily living. A facility pest sighting log, dated 09/24/25 through 02/20/26, showed mice and roach sightings in resident rooms and the dining room. The pest sighting log showed last preventive treatment was 02/17/26. The log did not document every pest sighting was treated after the sightings were recorded on the log. On 02/17/26 at 10:30 a.m., the dietary manager was asked if there was a roach and mouse problem. They stated, Yes ma'am, there is.On 02/19/26 at 11:20 a.m., the administrator was shown the live roaches. They stated they would contact their exterminator immediately. On 02/20/26 at 02:20 p.m., the maintenance supervisor was asked how often they cleaned the ice machine and if they had been told there were dead roaches inside the machine. The maintenance supervisor stated it was cleaned once monthly and whenever the staff reported a problem. They stated dead roaches were reported this morning and the ice machine was cleaned.