| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375303 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wewoka Healthcare Center | 1400 West First Street<br>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) |
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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**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<br>(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 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 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 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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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>On 02/26/26, an IJ situation was determined to exist related to the facility's failure to have effective administration who utilized its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility administration failed to:a. ensure residents' controlled medications were not misappropriated;b. establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation;c. ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled; andd. report an allegation of misappropriation of controlled medications to law enforcement and the state survey agency.On 02/26/26 at 3:26 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 02/26/26 at 3:52 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On 03/05/26 at 10:40 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Reporting: On 02/26/2026, the Administrator was reˆeducated and immediately began following the requirement to report all allegations or indications of misappropriation of controlled medications to the Oklahoma State Department of Health and local law enforcement.Document Routing: On 02/27/2026, all Licensed Nurses and CMAs were educated that all pharmacy medication receipts, completed narcotic count sheets, and any drugˆrelated documents must be turned in to the DON immediately at the end of each shift.Controlled Medication Receipt Process: On 02/26/2026, Licensed Nurses and CMAs were trained that all controlled medications are received from the pharmacy by a Licensed Nurse only (no CMA may accept, store, or sign for controlled substances).Administration Responsibilities: On 02/27/2026, Licensed Nurses were reˆeducated that only Licensed Nurses may dispense/administer controlled substances, ensuring secure chain of custody.FacilityˆWide Narcotic Audit: Between 02/26/2026 and 02/27/2026, Consultant Nurse completed a full controlledˆsubstance audit to ensure all narcotics were present and available according to current physician orders for all residents.Record Reconciliation: The DON reconciled all current narcotic records, aligning count sheets and MARs with current physician orders and physical stock.Pharmacy Consultant Audit: On 03/02/2026, the pharmacy consultant conducted an additional reconciliation of controlledˆsubstance records to validate accuracy and identify any irregularities.Pharmacy Notification System: Effective 03/02/2026, the pharmacy will notify the governing body and the Administrator of any outˆofˆsync or irregular narcotic requests/deliveries to detect and prevent misappropriation.Physician Notification: The attending physician was notified by the Administrator regarding the allegation, investigation, and medication availability to ensure uninterrupted pain management.QA Committee Review: On 03/02/2026, the findings, corrective actions, reconciliation outcomes, and reporting steps were presented to the Quality Assurance Committee for review and ongoing monitoring.Completed by 03/05/2026 at 5:00 PM.The IJ was lifted, effective 03/05/26, when all components of the plan of removal had been verified as completed. Multiple certified and licensed staff on different shifts were interviewed regarding the in-services they received. Pharmacy audits, police reports, state reported incidents, and QA agendas were reviewed. The deficiency remained at widespread level with the potential for more than minimal harm.Based on observation, record review, and interview, the facility failed to have effective administration who utilized its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility administration failed to:a. ensure residents' controlled medications were not misappropriated;b. establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation;c. ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled; andd. report an allegation of misappropriation of controlled medications to law enforcement and the state survey agency.The administrator identified 61 residents resided in the facilityFindings:An Administrator policy, revised<br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 04/2007, read in part, The Administrator is responsible for, but not limited to: Managing the day-today functions of the facility.Implementing, established resident care policies, personnel policies, safety and security policies, and other operational policies and procedures necessary to remain in compliance with current laws, regulations, and guidelines governing long-term care facilities.1.The facility failed to ensure controlled medications were not misappropriated for 2 (#2 and #6) of 5 sampled residents who were reviewed for medication misappropriation. Res #6 had 120 oxycodone/APAP tablets delivered, but 90 tablets were unaccounted for, with discrepancies between the medication administration record, count sheets, and receiving logs, as well as allegations of forged staff signatures and lack of follow-up on reported concerns. Res #2 had 90 hydrocodone/APAP tablets delivered, but 30 tablets were missing, with no documentation of receipt and missing count sheets. Staff were unable to locate the missing medications, and responsibilities for reconciliation were unclear. The ADON identified 21 residents received controlled pain medication.2. The facility failed to ensure written policies and procedures that prohibit and prevent misappropriation of residents' controlled medications were implemented for 1 (#6) of 7 sampled residents reviewed for reporting misappropriation of controlled medications. Res #6 had 120 oxycodone/APAP tablets delivered, but 90 tablets were unaccounted for, with discrepancies between medication records and count sheets, including undocumented administrations. A staff member reported that their signature had been forged on narcotic count sheets and stated the resident had only taken one dose; however, although this concern was reportedly brought to leadership, the administrator denied being notified, and no reports were made to state authorities or law enforcement as required by policy. Additionally, staff expressed confusion regarding responsibility for medication reconciliation and follow-up, further demonstrating a breakdown in oversight and adherence to facility procedures. The ADON identified 21 residents received controlled pain medication. 3. 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 5 sampled residents reviewed for medication misappropriation. Res #6 had 120 oxycodone/APAP tablets delivered; however, 90 tablets could not be accounted for, with missing medication cards, lack of documentation on the medication receiving log, and discrepancies between the count sheet and MAR, including undocumented doses and allegations of forged signatures. Res #2 had 90 hydrocodone/APAP tablets delivered, but 30 tablets were unaccounted for, with missing count sheets and no documentation of receipt. Staff interviews showed confusion regarding responsibility for reconciliation. The ADON identified 21 residents received controlled pain medication. On 02/27/26 at 1:15 p.m., the administrator stated they were responsible for ensuring freedom of misappropriation of controlled medications and accurate narcotic counts. They stated they had not monitored narcotics because they thought the nursing staff was monitoring them. The administrator stated the DON was responsible for controlled drug receipt, storage, and disposition but the facility had been without a DON during the months of December 2025 and January 2026. They stated relying on the medication staff to ensure proper accounting and reconciliation of controlled drugs was inappropriate. The administrator stated they had never been made aware of concerns regarding missing medications or allegations of misappropriation. They stated the pharmacy consultant periodically audits medications and had never voiced any concerns.On 03/02/26 at 11:20 a.m., the corporate administrator stated the facility was using an RN to fill in for the lack of a DON during the time the misappropriation occurred. They stated they assumed the RN would have overseen the controlled medication receipt, storage, and disposition process. The corporate administrator stated there was a breakdown in the chain of command which allowed misappropriation of medications to occur without anyone noticing immediately. They stated the break in processes was ultimately the administrator's responsibility.On 03/03/26 at 10:05 a.m., the COO stated the administrator communicated with them daily through phone calls and emails. They stated they had never been made aware of concerns regarding misappropriation of medications or the accuracy of narcotic counts until now. The COO stated the pharmacy consultant had conducted a drug audit the day before, but they were not aware of the results of the audit at this time. |

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| F 0865<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>**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 have an effective quality assurance program that acted on identified concerns and developed a plan of action to correct identified quality of care issues. On 02/26/26 at 3:26 p.m., the Oklahoma State Department of Health verified the existence of an IJ situation.On 02/26/26 at 3:48 p.m., the administrator was notified of the IJ situation and the IJ template was provided.Administrator was educated on having an effective QAPI program that identifies and implements corrective action for quality-of-care issues that include but not limited to reporting allegations of misappropriation of controlled medications to the Oklahoma State Department of Health and Law Enforcement. Inservice completed by corporate administrator on 2/27/26QA Committee Review: On 03/02/2026, the facility plan of removal showed the findings, corrective actions, reconciliation outcomes, and reporting steps were presented to the Quality Assurance Committee for review and ongoing monitoring. On 03/03/26 at 2:02 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health.The IJ was lifted, effective 03/05/26, when all components of the plan of removal had been verified as completed. Multiple certified and licensed staff on different shifts were interviewed regarding the in-services they received. Pharmacy audits, police reports, state reported incidents, and QA agendas were reviewed. The deficiency remained at widespread level with the potential for more than minimal harm.Based on record review and interview, the facility failed to have an effective quality assurance program that acted on identified concerns and developed a plan of action to correct identified quality of care issues. The administrator identified 61 residents resided in the facility. Findings:A facility policy titled Policy and Procedure manual for Quality Assurance Performance Improvement, dated 11/01/17, read in part, addresses clinical care-monitoring existing QM results, falls, medication errors, pressure ulcers, incident reports, resident/guests/families concern brought up, and review grievances. The committee will meet quarterly or more often.An undated diagnoses list for Res #6 showed the resident was admitted to the facility on [DATE] with diagnoses which included chronic pain, hypertension, and major depressive disorder.A physician's order for Res #6, dated 12/24/25, showed oxycodone/APAP (pain medication) 10-325mg, one tablet every six hours as needed. The physician's order showed the order was discontinued on 01/30/26.A 5-day MDS assessment for Res #6, dated 02/04/26, showed the resident had a BIMS score of 15 which indicated the resident was cognitively intact for daily decision making.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 controlled drug count sheet for Res #6, with a received date of 12/15/25, showed 30 tablets oxycodone/APAP 10-325mg were received. The form showed an additional 19 doses were administered that were not documented on the MAR as being administered to the resident.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 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 the resident never asked for pain medication and the only dose they took was the first one. They stated Resident #6 did not like the way it made them feel. CMA #1 reported 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. 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 while counting out the medication cart with CMA #1. 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 narcotic<br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 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. At 11:46 a.m., the ADON stated they only make sure the count on the sheet and the card match then it goes into lock up in the DON's office. The ADON stated it was usually the RN's responsibility to perform the medication reconciliation. At 12:09 p.m., the administrator stated it should be the RN or charge nurse reconciling the count sheet with the MAR. The administrator stated it would be the DON going forward. At 12:35 p.m., LPN #2 stated they did not administer Res #6 any narcotics and they did not sign the count sheet.An interview with a pharmacy staff confirmed 120 tablets oxycodone/APAP 10-325mg were delivered to the facility on [DATE] for Res #6.No documentation present that an investigation or PIP was implemented with the QAPI committee. |

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| F 0602<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**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 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<br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 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. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375303 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wewoka Healthcare Center | 1400 West First Street<br>Wewoka, OK 74884 |

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|---|---|
| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**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<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on record review and interview, the facility failed to employ a full-time DON and ensure RN coverage for eight consecutive hours, seven days a week.The administrator identified 61 residents resided in the facility. Findings:A PBJ Staffing Data Report, dated 07/01/25 through 09/30/25, the fourth quarter of fiscal year 2025, showed the facility did not provide RN coverage on 18 of the 92 days in that quarter. The dates identified on the PBJ report as not having RN coverage in 07/2025, 08/2025, and 09/2025 were 07/05/25, 07/06/25, 07/20/25, 07/27/25, 08/03/25, 08/10/25, 08/23/25, 08/24/25, 09/05/25, 09/07/25, 09/08/25, 09/09/25, 09/13/25, 09/14/25, 09/16/25, 09/19/25, and 09/23/25.A facility document titled Springhill time clock report, dated 07/01/25 through 02/24/26, showed there was not a RN on duty on 07/05/25, 07/06/25, 07/20/25, 07/27/25, 08/03/25, 08/10/25, 08/23/25, 08/24/25, 09/05/25, 09/07/25, 09/08/25, 09/09/25, 09/13/25, 09/14/25, 09/16/25, 09/19/25, and 09/23/25.On 02/24/26 at 12:49 p.m., the BOM stated there was no RN coverage on 07/05/25, 07/06/25, 07/20/25, 07/27/25, 08/03/25, 08/10/25, 08/23/25, 08/24/25, 09/05/25, 09/07/25, 09/08/25, 09/09/25, 09/13/25, 09/14/25, 09/16/25, 09/19/25, and 09/23/25.On 02/24/26 at 12:49 p.m., the BOM stated the last day of employment for DON #1 was on 09/04/25. Former DON #2's employment dates were 09/10/25 through 12/02/25.They stated the current DON began employment on 02/09/26.On 02/24/26 at 12:58 p.m., the administrator stated the facility was without a full-time DON from 09/04/25 through 09/10/25 and 12/02/25 through 02/09/25. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, record review, and interview, the facility failed to ensure dishes were air dried.The dietary manager identified 61 residents received dietary services from the kitchen. Findings: On 02/17/26 at 10:57 a.m., a tour of the kitchen was conducted. Bowls and cups were observed to be stacked inside each other and were still wet. On 02/19/26 at 2:25 p.m., plates and pans were observed to have water in between each dish and pan. The pans were stored inside a larger metal square pan with standing water in the bottom of the square pan. On 02/19/26 at 2:28 p.m., dietary aide #1 stated they knew the policy for storing dishes and pans and they should be dry before being put away, but sometimes the dishes got put away wet if they were in a hurry. A facility report titled Food Safety and Sanitary Checklist from the dietician, dated 10/23/25, showed a checkmark on the No column that dishes and pans were not air dried and stored dry. On 02/20/26 at 1:00 p.m., the dietary manager stated to ensure staff was following the policy and procedures to prevent foodborne illnesses, dishes and cooking utensils were to be clean and stored in sanitary conditions. The dietary manager stated, I just keep working with them and reminding them. I have new ones that I'm working with. |

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| F 0837<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.<br><br>Based on record review and interview, the governing body failed to oversee the facility and coordinate with the facility administrator to ensure:a. residents were free from misappropriation of controlled medications;b. a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation;c. drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled;d. allegations of misappropriation of controlled medications were reported to law enforcement and the state survey agency; e. allegations of misappropriation of controlled medications were investigated per the facility's abuse prevention policy; andf. an effective quality assurance program that acted on identified concerns and developed a plan of action to correct identified quality of care issues. The administrator identified 61 residents resided in the facility.Findings:An Administrative Management (Governing Board) policy, revised 10/2017, read in part, The governing board is responsible for, but is not limited to: Oversight of facility care and services in accordance with professional standards of practice and principles.Establishment of a system whereby the Administrator reports to the governing body, including: method of communication from the administrator, frequency of reports, specific information that will be reported, how and when the governing body will respond to the Administrator's reports; and how the Administrator will be held accountable for facility management and operations.1.The facility failed to ensure controlled medications were not misappropriated for 2 (#2 and #6) of 5 sampled residents who were reviewed for medication misappropriation. Res #6 had 120 oxycodone/APAP tablets delivered, but 90 tablets were unaccounted for, with discrepancies between the medication administration record, count sheets, and receiving logs, as well as allegations of forged staff signatures and lack of follow-up on reported concerns. Res #2 had 90 hydrocodone/APAP tablets delivered, but 30 tablets were missing, with no documentation of receipt and missing count sheets. Staff were unable to locate the missing medications, and responsibilities for reconciliation were unclear. The ADON identified 21 residents received controlled pain medication.2. The facility failed to ensure written policies and procedures that prohibit and prevent misappropriation of residents' controlled medications were implemented for 1 (#6) of 7 sampled residents reviewed for reporting misappropriation of controlled medications. Res #6 had 120 oxycodone/APAP tablets delivered, but 90 tablets were unaccounted for, with discrepancies between medication records and count sheets, including undocumented administrations. A staff member reported that their signature had been forged on narcotic count sheets and stated the resident had only taken one dose; however, although this concern was reportedly brought to leadership, the administrator denied being notified, and no reports were made to state authorities or law enforcement as required by policy. Additionally, staff expressed confusion regarding responsibility for medication reconciliation and follow-up, further demonstrating a breakdown in oversight and adherence to facility procedures. The ADON identified 21 residents received controlled pain medication. 3. 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 5 sampled residents reviewed for medication misappropriation. Res #6 had 120 oxycodone/APAP tablets delivered; however, 90 tablets could not be accounted for, with missing medication cards, lack of documentation on the medication receiving log, and discrepancies between the count sheet and MAR, including undocumented doses and allegations of forged signatures. Res #2 had 90 hydrocodone/APAP tablets delivered, but 30 tablets were unaccounted for, with missing count sheets and no documentation of receipt. Staff interviews showed confusion regarding responsibility for reconciliation. The ADON identified 21 residents received controlled pain medication. 4. The facility failed to have a quality assurance program that acted on identified concerns and developed a plan of action to correct identified quality of care issues. There was no evidence the concerns of medication<br>(continued on next page) |

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| F 0837<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | discrepancies were addressed through the QAPI process. Although staff reported the issue to leadership, the administrator denied awareness, and no action plan, performance improvement project (PIP), or documentation of review by the QAPI committee was found. The administrator identified 61 residents resided in the facility.On 03/02/26 at 11:20 a.m., the corporate administrator stated their role in the facility was to provide support to the administrator in all care areas. They stated the administrator would contact them via the phone or emails with concerns. The corporate administrator stated the facility had no DON for several weeks and they assumed the RN providing shift coverage for the role of the DON would ensure proper receipt, storage, and accounting of controlled medications. They stated the administrator was ultimately responsible for the breakdown of the chain of custody of the controlled medications.On 03/02/26 at 2:45 p.m., the administrator stated the COO was the only member of the governing body. They stated having reported any problems or concerns to the COO on a regular basis through phone conversations and emails. The administrator stated they were not aware of the allegations of misappropriated or missing controlled medications prior to the survey.On 03/03/26 at 10:05 a.m., the COO stated they provided oversight of daily operations and was considered the governing body. They stated the administrator communicated with them daily through phone calls and emails. The COO stated the administrator had not reported any allegations of misappropriated controlled drugs or missing controlled medications until the immediate jeopardy situation was communicated to them. They stated the pharmacy consultant had been present in the building the day before to audit medication counts, but the results of the audit had not been reported to them at this time. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**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. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to transmit resident MDS assessments to CMS within 14 days of completion for 3 (#15, 26, and #28) of 16 sampled residents reviewed for resident assessments.The administrator identified 61 residents resided in the facility.Findings:A MDS Completion and Submission Timeframes policy, revised July 2017, read in part, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.1. An undated face sheet showed Res #15 was admitted to the facility on [DATE].Res #15's quarterly assessment showed completion on 12/16/25.A CMS submission report showed the assessment was submitted on 02/23/26.2. An undated face sheet showed Res #26 was admitted to the facility on [DATE].Res #26's quarterly assessment showed completion on 12/23/25.A CMS submission report showed the assessment was submitted on 02/23/26.3. An undated face sheet showed Res #28 was admitted to the facility on [DATE].Res #28's annual assessment showed completion on 12/16/25.A CMS submission report showed the assessment was submitted on 02/23/26.On 02/24/26 at 2:46 p.m., the corporate MDS coordinator stated all three of the MDS assessments had been flagged by the computer system for possible quality measures upon completion and should have been reviewed at that time. They stated the error was just identified and the assessments were submitted on 02/23/26. The corporate MDS coordinator stated the assessments were not submitted within required 14-day time frame. |

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|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, record, review, and interview, the facility failed to ensure a medication error rate of less than five percent for 2 (#34 and #43) of 3 sampled residents observed receiving medications. The facility had 3 errors out of 26 opportunities resulting in a 11.54% error rate.The administrator identified 61 residents resided in the facility. Findings:An Administering Medications policy, dated 12/2022, read in part, Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) or the facility is on block times.1.On 02/20/26 at 9:15 a.m., CMA #5 was observed to administer Depakote (an anticonvulsant) 500mg and Gabapentin (an anticonvulsant) 300mg to Res #34. An undated face sheet showed Res #34 was admitted to the facility with diagnoses which included bipolar, anxiety, and post-traumatic stress disorder.A physician order for Res #34, dated 02/01/26, showed to administer Depakote delayed release 500mg, give one tablet by mouth two times a day.A physician order for Res #34, dated 02/02/26, showed to administer Gabapentin 300mg, one capsule by mouth three times a day.A MAR for Res #34, dated 02/01/26 through 02/28/26, showed Depakote delayed release 500 mg, give one tablet by mouth two times a day at 8:00 a.m. and 2:00 p.m.A MAR for Res #34, dated 02/01/26 showed 02/28/26, showed Gabapentin 300 mg, give 1 tablet by mouth three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m.2. On 02/20/26 at 9:25 a.m., CMA #5 was observed to administer Depakote 125mg to Res #43. An undated face sheet showed Res #43 was admitted to the facility with diagnoses which included major depressive disorder, schizophrenia, and anxiety disorder.A physician order for Res #43, dated 02/02/26, showed to administer Depakote delayed release 125 mg by mouth three times a day.A MAR for Res #43, dated 02/01/26 through 02/28/26, showed Depakote 125 mg by mouth three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m.On 02/20/26 at 9:33 a.m., CMA #5 stated the medications that were scheduled at 8:00 a.m. were late. On 03/05/26 at 1:33 p.m., the ADON stated the medications were late and they only had an hour before or an hour after the scheduled time. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375303 | A. Building<br>B. Wing | 03/05/2026 |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**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<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to accurately code MDS data for 1 (#38) of 6 sampled residents reviewed for MDS accuracy. The administrator identified 61 residents resided in the facility. Findings: On 02/23/26 at 2:09 p.m., LPN #3 was observed to administer one carton of Isosource liquid nutrition, 1.5 calorie/milliliter, and one capsule of Benadryl 25mg per PRN orders for right leg itching, via PEG tube to Resident #38. The admission record dated 12/30/25, showed Resident #38 was admitted [DATE] with diagnoses which included cerebral palsy, achalasia of cardia, dysphagia, and bipolar disorder. An admission MDS assessment for Res #38, dated 01/05/26, showed the resident had a BIMS score of 14 indicating intact cognition. Section K of the MDS did not indicate resident having a feeding tube while a resident. A care plan for Res #38, updated 01/08/26, showed the resident would maintain adequate nutritional status by receiving ordered PEG tube feedings, and could receive pureed meals as tolerated in the dining room. Physician's orders for Res #38, dated 02/2026, showed the resident could be served a diet as tolerated. Res #38 had an order for Isosource, 1.5 calorie/milliliter, administer one carton, three times daily via PEG tube.medications included:a. Ingrezza 40mg daily used to treat tardive dyskinesia,b. Clozaril 100mg at bedtime, antipsychotic used to treat schizophrenia, c. Clozaril 25mg at bedtime, d. Flonase nasal spray daily, corticosteroid to treat allergic rhinitis, e. Lithium 300mg (3 tabs) daily, a mood stabilizer to treat bipolar disorder, f. Lamictal 100mg (2 tabs) daily, used to treat epileptic seizures, g. Trintellix 10mg every evening, used to treat major depressive disorder,h. Clonidine 0.1mg twice daily, used to treat high blood pressure, i. Miralax daily, a laxativej. Tricor 145mg daily, used to reduce tryglycerides in the blood,k. Pepcid 40mg daily, used to treat/prevent stomach ulcers, and l. PRN Benadryl (antihistamine), Tylenol(pain relief), and Milk of Magnesia (constipation relief) All crushable medications given via PEG. Capsules are opened and given via PEG. On 02/24/26 at 12:41 p.m., MDS coordinator #1 verified the question in Section K of the MDS should have been checked Yes indicating Res #38 did have a feeding tube. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**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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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure expired medications/supplies were removed from the medication/supply room for 1 of 1 medication storage room observed.The administrator identified 61 residents resided in the facility. Findings: A policy titled Storage of Medications, dated 04/2019, read in part, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. On 02/23/26 at 1:48 p.m., the North medication and supply room was observed with CMA #2.The following supplies were found to be expired:a.one central line tray w/chloraprep with an expiration date of 03/31/25,b. one IV administration set with an expiration date of 12/14/24,c. one IV administration set with an expiration date of 03/11/25,d. eight no-sting skin barrier film wipes with an expiration date of 06/09/23,e. three boxes of Gelocast with an expiration date of10/10/24,f. three packages of Statlock stabilization devices with an expiration date of 06/28/25,g. three Assure ID - tuberculin safety syringes with an expiration date of 01/05/23,h. one ESwab collections and transport system with an expiration date of 07/29/25, [NAME]. 4 boxes of Glucocard Vital, blood glucose strips, with and expiration date of 11/02/25. On 02/23/26 at 2:05 p.m., the ADON stated the expired items should have been removed by the nurses. |