

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER Shady Rest Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 South Adair Pryor, OK 74361	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 07/08/25 past non-compliance immediate jeopardy situations were determined to exist related to the facility's failure to:a. secure Resident #2 during transport in the facility van. On 06/18/25 the van driver had to brake suddenly, and Resident #2 fell forward from the wheelchair hitting their head and right knee on the row of seats in front of them; andb. ensure the safety of Resident #1 who was at risk for elopement. On 06/22/25 at 8:17 p.m., a facility video showed Resident #1 left the facility through the kitchen door and walked North down the alley. At 8:27 p.m., the video showed Resident #1 at the front door of the facility and then they walked South down [NAME] street.Based on observation, record review, and interview, the facility failed to ensure:a. seat belts were in proper working order for 1 (#2) of 3 sampled residents reviewed for transportation safety; and b. prevent the elopement of 1 (#1) of 3 sampled residents reviewed for elopement. The administrator identified 35 residents resided in the facility. Findings:1. A quarterly assessment, dated 05/22/25, showed Resident #2 was cognitively intact with a BIMS of 14. A final Incident Report Form, dated 06/18/25, showed the seatbelt attachment was not in working order and Resident #2 was injured during transportation. A progress note, dated 06/18/25, showed Resident #2 was sent via ambulance to the hospital emergency room for evaluation after complaining of neck pain and right knee pain. A hospital Discharge summary, dated [DATE], showed Resident #2 was diagnosed with a strain of the neck muscles, closed fracture of the nasal bone, closed head injury, and contusion of the right knee. A service repair invoice, dated 06/20/25, showed the lap belt retractor device needed to be replaced. The invoice showed multiple missing tie down pieces for the lap belt were installed. A care plan for Resident #2, revised 06/20/25, read in part, Encourage me to sit up straight when in my w/c [wheelchair], especially if I am in the van. Facility staff will sit in the back with me on any future transports. The equipment in the van will be checked for appropriateness, safety of function. A safety checklist is to be initiated before any transport by staff, going forward.A Quality Assessment and Performance Improvement form, dated 06/19/25, showed 1. Pre-travel safety checklist in place inside transport van; 2. Staff in-service education regarding safety during transport van; 3. Driver suspended pending investigation of situation; and 4. Certified nurse aide/support staff will sit in the back of the van with any resident. Plan of completion date was 06/20/25. On 07/08/25 at 9:34 a.m., Resident #2 stated they were in the van with the maintenance supervisor driving the van. Resident #2 stated the driver nearly missed the exit on the expressway causing them to brake hard. Resident #2 stated they were flung forward hitting their face and right knee on the row of seats in front of them. Resident #2 stated the wheelchair was secured to the floor of the van, but the lap belts did not work. Resident #2 stated the AD was also in the van.On 07/08/25 at 10:07 a.m., the AD stated they were in the van on 06/18/25 during the transport of Resident #2 to a physician's appointment. The AD stated when the van driver attempted to exit off the expressway a car pulled in front of them causing the driver to pump the breaks hard. The AD stated Resident #2 was flung forward hitting their head on the row of seats in front of them. The AD stated the van driver was not on the phone during the transport. On 07/08/25 at 10:19 a.m., the van driver stated the seatbelt for wheelchairs was not working. They stated they had to brake harder than usual, and Resident #2 fell forward. They stated they were not on the phone, although they did use navigation. The van driver stated Resident #2 stated they were fine and declined the emergency room at that time.On 07/08/25 at 10:40 a.m., administrator #1 stated the van was repaired by the safety devise vendor, who also did an in-service with the van driver on using the seat belts. They stated the facility had initiated a safety check list that must be completed before transporting a resident. Administrator #1 stated they monitored this check list. The in-service was not provided by the end of the survey.On 07/08/25 at 11:30 a.m., the van driver stated they had noticed the seatbelt for wheelchair occupants was not working in the middle of May. They stated they reported this to two other administrators at sister facilities. On 07/08/25 at 1:51 p.m., administrator #2 from a sister facility stated they had not received a report from anyone the seatbelts were not working in the facility van. On 07/08/25 at 1:55 p.m., administrator #3 from a sister facility stated they had not received a report from anyone the seatbelts were not working in the facility van. 2. On 06/25/25 at 1:30 p.m., the route Resident #1 walked was observed by car. [NAME] street was observed to be a moderately busy residential street without curbs. On 06/25/25 at 3:32 p.m. the keypad locks were observed on the door from the dining room to the kitchen and on the door from the kitchen to the outside.An admission assessment, dated 05/23/25, showed Resident #1 was moderately impaired for making decisions with a BIMS score of 10</p>		