

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2026
NAME OF PROVIDER OR SUPPLIER  Nowata Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  436 South Joe Nowata, OK 74048	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to report an allegation of a crime toward a resident to OSDH and local law enforcement within 2 hours for 1 (#4) of 3 sampled residents reviewed for abuse. The DON identified 32 residents resided in the facility. Findings: A facility policy titled Policy and Procedure Regarding Responsibility of Reporting Allegations of Resident Abuse, Criminal Acts, Injury of Unknown Source, Neglect, Misappropriation of Property, and Exploitation, dated 10/11/22, read in part, It is the policy of this facility to act on all allegations of abuse, neglect, misappropriation of resident property, exploitation, injuries of unknown source and suspected criminal acts which included reporting the allegation withing the required time frame to the appropriate authorities. A quarterly assessment for Res #4, dated 04/18/25, showed the resident had a brief interview for mental status score of 12, indicating moderate cognitive impairment. A Transfer to Hospital Summary, dated 06/24/25 at 1:45 p.m., was found in the progress note section of Res #4's EMR. The summary, read in part, Note Text: Order received from [doctor name withheld] to transfer resident to hospital due to increased confusion, hallucinations, shortness of breath and abdominal breathing of 30 breaths per minute. The summary showed the facility nurse on duty had called the local acute care hospital and informed their staff the resident had received one half of a Xanax (antianxiety medication/controlled substance) tablet from a family member of the resident. A review of Res #4's EMR including active and discontinued medications, and the June 2025 medication and treatment administration records showed the resident was not ordered Xanax. On 01/29/26 at 10:13 a.m., LPN #1 was asked if they had any information regarding Res #4 having received a Xanax tablet from a family member. LPN #1 stated during a lunch break on 06/24/25 a family member of Res #4 had informed them they had given Res #4 one of their own Xanax tablets because the resident was yelling out for their dead husband. LPN #1 was asked what they had done with that information. They stated just after receiving the information about the Xanax, LPN #2 called them and told them Res #4 was going to be sent to the hospital. LPN #1 stated they informed LPN #2 during that call about the Xanax tablet having been given to the resident. They stated the ambulance staff was notified about the Xanax. On 01/29/26 at 10:30 a.m., LPN #2 was asked if they had any information about a Res #4 having been administered a Xanax tablet by a family member. They stated they did recall that had occurred but could not remember who had informed them of the incident. They stated they recalled being told of the specific family member who allegedly gave the medication to the resident. They stated they then called that family member who told LPN #2 that they had given the tablet to Res #4 and why they had done so. They stated they could not recall. On 01/29/26 at 10:54 a.m., the administrator stated they did recall the incident as it happened shortly after they began working at the facility. They stated the DON at the time, LPN #2, had informed them of the incident and that they had contacted the family member and confirmed the incident had occurred. They stated they recalled having a discussion with LPN #2 and the corporate nurse about reporting the incident, but they did not believe it was a reportable</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  375354	Facility ID:  375354  If continuation sheet Page 1 of 2

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>incident because there was no place on the incident reporting form (ODH 283) for the incident. The administrator stated if someone administered a resident their personal medication (controlled substance), they should have reported it as a criminal activity to OSDH. On 01/30/26 at 12:04 p.m., the administrator stated they had not fully followed their abuse policy.</p>