

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Wagoner Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 205 North Lincoln Avenue Wagoner, OK 74467	

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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171</p> <p>Based on observation and interview, the facility failed to ensure the call light system was functioning in one of six occupied rooms resident rooms reviewed for call light functionality.</p> <p>The administrator reported the census was 53.</p> <p>Findings:</p> <p>A facility policy, reviewed 07/24, titled Maintenance Service read in part, .Functions of maintenance personnel include, but are not limited to .Maintaining the paging and nurse call system in good working order .</p> <p>On 10/08/24 at 10:05 am, LPN #1 stated when the call light was activated a light should illuminate in the hallway by the resident's door.</p> <p>At 10:10 am, CNA #1 stated when they observed that the light in front of a resident's door was illuminated that indicated the resident needed assistance.</p> <p>At 11:50 am, the call system in room [ROOM NUMBER] was activated, no light was illuminated in the hallway or at the nurse's desk. LPN #2 stated the call light for room [ROOM NUMBER] was not functioning.</p> <p>At 1:30 am, the maintenance supervisor stated they tested the call lights on a weekly basis, but they did not document the tests.</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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