Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375371	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health Services	1008 Arkansas Street Arkoma, OK 74901

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42171 On 03/03/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to have a system in place to ensure dependent residents were repositioned every two hours to prevent new and worsening pressure ulcers. On 03/03/25 at 6:00 pm, the OSDH was notified and verified the existence of the IJ situation. On 03/03/25 at 6:15 p.m., the facility administrator and DON were notified of the IJ situation and provided a copy of the IJ template. On 03/05/25 at 10:06 a.m., an acceptable plan of removal was submitted to the OSDH. The plan of removal, read in part, 1. DON/Designee Completed 100% Care Plan Audit to ensure Interventions are in place to prevent further Skin Breakdown on 3/3/25 and 3/4/25. 2. DON/Designee In-serviced Licensed Nursing Staff on 3/3/25 regarding: Facility Policy on Turn Schedule. Repositioning Policy and Procedure. Shift Documentation of ADL Care including Turning and Repositioning. 3. DON/ADON Completed 100% Skin Sweep with No New Skin Issues Identified on 3/3/25. 4. RNC [regional nurse consultant] In-serviced Admin [administrator]/DON/ADON and Provided Education on Interventions to prevent Skin Breakdown on 3/3/25. All In-services to Licensed Nursing Staff were completed on 3/3/25 by 2000 [8:00 p.m.]. 1. DON/Designee In-serviced CNA/CMA Staff on 3/3/25 regarding: Facility Policy on Turn Schedule. (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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Repositioning Policy and Procedure. Shift Documentation of ADL Care including Turning and Repositioning 2. Resident #2 wound was assessed on 3/4/25 upon return from Hospital and noted to have declined with 3 New Non-Facility Acquired Wounds. 3. DON/Designee Verified Physician and Family are Aware with Appropriate Treatments in Place. 4. Resident #2 will be followed weekly by [name withheld] Wound Specialists. 5. Documented Turn and Repositioning Schedule initiated 3/3/35 at 2000 [8:00 p.m.]. All In-services to CNA/CMA completed on 3/3/24 by 2000. On 03/05/25 at 5:22 p.m., the IJ was removed when all components of the plan of removal had been verified. The deficiency remained as an isolated level with potential for more than minimal harm. Based on observation, record review and interview, the facility failed to have a system in place to ensure dependent residents were repositioned every two hours to prevent new and worsening pressure ulcers for 1 (#2) of 3 sampled residents reviewed for pressure ulcers. The DON identified five residents in the facility with pressure ulcers. Findings: On 3/03/25 at 5:15 p.m., a tour of the facility was conducted with the DON. The repositioning schedule in the ADL book showed dependent residents were be positioned on their right side from 4:00 p.m. until 6:00 p.m. Zero out of 32 dependent residents were observed to be positioned on their right side. An undated facility policy titled Repositioning read in part, A turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated .Residents who are in bed should be on at least every two hour ([every]2 hour) repositioning schedule. Resident #2 had diagnoses which included chronic respiratory failure. A skin assessment, dated 11/25/24, showed Resident #2 was at high risk for developing a pressure ulcer. A care plan, date initiated 11/25/24, showed Resident #2 was to be turned and repositioned every two hours. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Riverside Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Arkansas Street Arkoma, OK 74901	

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An admission minimum data set assessment, dated 12/02/24, showed Resident #2 was totally dependent on staff for repositioning and did not have any pressure ulcers upon admission. The assessment also showed Resident #2 was on a turning/repositioning program. A nurse note, dated 01/10/25 at 4:00 p.m., showed Resident #2 was found to have a fluid filled blister to the left buttock and an open area to the right buttock. The note also showed the physician was notified and wound care orders were received. A physician order, dated 01/10/25, showed Resident #2 was to receive daily wound care. The order showed the wound was to be cleaned with normal saline, patted dry, then Bactroban was to be applied, and the wound was to be covered with foam dressing. A physician order, dated 01/20/25, showed Resident #2 was to receive daily wound care. The order showed the wound was to be cleaned, patted dry, Hydrogel was to be applied, and the wound was to be covered with a padded dressing. A wound progress note, dated 01/27/25, showed Resident #2 had an unstageable pressure ulcer to the sacrum measuring 5.0 cm x 4.0 cm x 0.1 cm. The note also showed the wound had very little drainage and no odor. A wound progress note, dated 02/03/25, showed Resident #2 had an unstageable pressure ulcer to the sacrum measuring 7.0 cm x 5.0 cm x no depth documented. The note also showed the wound had very little drainage and no odor. A wound progress note, 02/10/25, showed Resident #2 had an unstageable pressure ulcer to the sacrum measuring 8.0 cm x 5.5 cm x no depth documented. The note also showed the wound had a moderate amount of drainage and a foul odor. A nurse note dated 02/10/25 at 4:07 p.m., showed Resident #2's wound was declining as evidenced by a foul odor, brown/yellow slough on the wound bed and moderate amounts of yellow/brown drainage. The note also showed the physician was notified and orders were received. A nurse note dated 02/17/25 at 11:00 a.m., showed Resident #2 was lethargic and would not arouse to a sternal rub, the note showed the physician was notified and the resident was being sent to the hospital. The note showed the wound to the sacrum now measured 6 cm x 8 cm x 1.5 cm with undermining from 6-12 o'clock. On 02/24/25 at 2:45 p.m., CNA #1 stated that dependent residents were turned every two hours and the ADL book at the nurse's desk told them what position the residents should be in at any given time. CNA #1 stated they did not document when residents were turned. On 02/24/25 at 2:47 p.m., CNA #2 stated the ADL book told them what position the residents needed to be in, but they did not document the residents had been repositioned. On 02/24/25 at 3:04 p.m., LPN #2 stated they made rounds to ensure residents were being turned. An After Visit Summary, dated 02/26/25, Showed Resident #1's primary hospital diagnosis was a pressure sore on the sacrum. The summary also showed additional diagnoses which included sepsis. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse note, dated 02/26/25 at 1:00 p.m., showed that Resident #2 had returned from the hospital with a diagnosis of pressure ulcer to the sacrum and VRE in the urine and wound. On 03/03/25 at 4:32 p.m., LPN #2 stated they did not have a list of residents that should be repositioned every two hours. On 03/03/25 at 4:33 p.m., CNA #8 stated the ADL book had a list of residents that required repositioning every two hours. CNA #8 reviewed the ADL book and stated that it did not contain a list of residents that required repositioning. CNA #8 then stated all dependent residents should be turned every two hours. CNA #8 stated they did not document when a resident was turned or if they refused to be turned. On 03/03/25 at 4:37 p.m., CNA #3 stated they did not have a list of who needed to be repositioned, and they did not document when a resident was turned or when a resident refused to be repositioned. On 03/03/25 at 4:45 p.m., the DON stated the CNAs documented in the ADL book when residents were repositioned. After reviewing the ADL book, the DON stated it was not being documented when residents were repositioned. They also stated that if a resident refused, the CNA should notify the charge nurse and document the resident refused. The DON stated the charge nurses and the DON should be monitoring to ensure the CNAs were repositioning residents as ordered and documenting when the residents were repositioned. On 03/03/25 at 5:20 p.m., the DON stated dependent residents should be on their right side until 6:00 p.m., but they were not. They also stated residents were not being repositioned appropriately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 Based on record review and interview, the facility failed to ensure complete and accurate documentation for 1 (#2) of 5 sampled residents reviewed for complete and accurate medical records. The DON reported the facility census was 39. Findings: A facility policy titled Charting and Documentation, revised 07/2017, read in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Resident #2 was admitted on [DATE] and had diagnoses which included chronic respiratory failure. A review of Resident #2's medical records did not show any physician progress notes for Resident #2. On 03/03/25 at 1:17 p.m., physician #1 stated they had seen Resident #2 in person a couple of times since there was a wound noted on 01/10/25. They also stated they had documentation of these visits at the office. On 03/03/25 at 3:15 p.m., the DON stated physician #1 had seen Resident #2 in person on 01/15/25 and 02/12/25. They stated Resident #2's medical records did not contain documentation of these visits.