

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Riverside Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, record review, and interview, the facility failed to update behavior care plans for 3 (#1, 2, and #4) of 3 sampled residents whose care plans were reviewed for their interventions in the management of routinely displayed inappropriate behavior. Findings: 1. On 07/27/25 at 3:15 p.m., Resident #1 was observed entering the dining room. Resident #2 was observed sitting at a table in the corner of the dining room, with windows located on both walls of the corner. Resident #1 stopped and stared in the direction of Resident #2 for several minutes while mumbling unintelligible words under their breath. When Resident #1 was asked what they were saying, the resident only smiled and shook their head no. Several seconds later, Resident #2 smiled and pointed out the window as an ambulance arrived with their emergency lights on. A nurse's progress note, dated 02/09/25, showed Resident #1 yelled at other residents, attempted to grab other residents, punched another resident, blocked doorways/staff access to other residents, entered other resident rooms and refused to leave, and maneuvered up and down the hallway and screamed and yelled at other residents. The progress notes showed Resident #1 could not be redirected. Resident #1 was sent to the hospital, received haloperidol (an antipsychotic with a sedative effect) and returned to the facility with a diagnosis of agitation. An incident report, dated 02/09/25, showed Resident #2 reported to staff that Resident #1 struck them in the chest. The report showed Resident #2 struck Resident #1 across the face in retaliation. A nurse's progress note, dated 02/11/25, read in part, Conferenced with [resident's physician name withheld] in regards to recent aggressive/combative behaviors. A care plan, dated 02/11/25, showed Resident #1 was at risk for behaviors, including verbal outbursts. The care plan showed the goal was to be free from negative behaviors over the next 90 days. The care plan interventions included staff interacting with Resident #1 in a calm manner, medication administered per orders, behaviors to be monitored daily, behavior to be reported to the physician, and social services to visit the resident weekly. The care plan did not address what signs/symptoms may indicate potential escalation in negative behaviors, what negative behaviors the resident exhibited/staff were to monitor, what staff were to do when the resident exhibited negative behaviors, and/or how the staff were to protect Resident #1 and other facility residents when Resident #1 exhibited negative behaviors. A nurse's progress note, dated 03/10/25, showed Resident #1 grabbed the wheelchair of Resident #2. In response, Resident #2 grabbed the arm of Resident #1 which resulted in a 1cm x .01cm abrasion to the left forearm of Resident #1. The progress note showed the residents were separated and Resident #1 received treatment for their abrasion and education to ask for help with moving other residents' wheelchairs. An incident report, dated 03/10/25, showed Resident #1 exchanged words with Resident #2, then reached out and grabbed the wheelchair Resident #2 occupied. Resident #2 then grabbed Resident #1 around the arm and when Resident #1 pulled their arm away, they received a small abrasion to their lower left arm. A quarterly assessment, dated 06/09/25, showed Resident #1's speech was usually understood, the resident usually understood others, was severely impaired in cognition with a BIMS score of 0, and exhibited no behaviors. The assessment showed the resident had profound intellectual disabilities, psychotic disorder, depression, and anxiety. A nurse's progress note, dated 06/15/25, showed Resident #1 had increased agitation during the shift, yelled at other residents, accused others of calling the police and/or trying to hit Resident #1, and attempted to enter other resident rooms without their permission. The note showed redirection was used without success. A physician's progress note, dated 06/18/25, read in part, This is a [resident's age omitted] year-old .with behavioral disorder. [They've] been more aggressive and attempting to hit other residents within the facility. [They] will not talk .Impression: Behavioral disorder .Plan: it was discussed with [them] about [their] behaviors. The note showed the resident shook their head in understanding of the discussion. Staff were to continue to monitor and report behaviors. The progress note did not address interventions for the behaviors. A nurse's note, dated 06/22/25, showed Resident #1 woke in an agitated state and attempted to physically attack other residents assembled in the dining room for breakfast. The note read the staff's attempt to redirect was unsuccessful. A nurse's progress note, dated 07/20/25, showed Resident #1 had multiple verbal behavioral outburst toward other residents and staff members. The note showed staff utilized redirection, snacks, diversional activities, one on one time with staff, and family intervention were unsuccessful. On 07/21/25 at 3:25 p.m., Resident #5 stated Resident #1 would be great one day and another day be very adversarial. The resident stated when Resident #1 was adversarial toward them, they did the same back to Resident #1. Resident #5 stated at times, the staff would</p>		