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	02/27/2026

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 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure CMAs had the proper certifications to pass medications for 3 (#1, 2, and #3) of 8 sampled CMAs reviewed for certifications to pass meds via a gastrostomy tube.The DON identified 24 residents received medications through their peg tubes. An undated Medication Administration policy, read in part, medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.1.On [DATE], upon reviewing CMA #1's certifications, CMA #1's advanced gastrostomy certification showed to have expired on [DATE].Resident #1's 10/2025 MAR showed CMA #1 had administered medications to Resident #1 on [DATE] through their peg tube (feeding tube into the stomach).2.On [DATE], upon reviewing CMA #2's certification, CMAs #2s advanced gastrostomy certification had expired on [DATE].Resident #1's 10/2025 MAR showed CMA #2 had administered medications to Resident #1 on [DATE], [DATE], and [DATE] through their peg tube.Resident #1's 11/2025 MAR showed CMA #2 had administered medications to Resident #1 on [DATE], and [DATE] through their peg tube.On [DATE] at 2:48 p.m., CMA #2 stated they were allowed to pass medications through a peg tube and do the feedings.3.On [DATE], upon reviewing CMA #3's certification, CMA #3's advanced gastrostomy certification had on [DATE].Resident #1's 10/2025 MAR showed CMA #3 had administered medications to Resident #1 on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] through their peg tube.Resident #1's 11/2025 MAR showed CMA #3 had administered medications to Resident #1 on [DATE], [DATE], [DATE], [DATE], and [DATE] through their peg tube.Resident #1's 12/2025 MAR showed CMA #3 had administered medications to Resident #1 on [DATE], [DATE], [DATE], [DATE], and [DATE] through their peg tube.On [DATE] at 10:51 a.m., the DON stated one of the nurses brought it to their attention a peg tube medication had already been administered, and CMA #1 was the only CMA not certified to work the medication carts. The DON stated they began an investigation and CMA #1 just never returned after being suspended.On [DATE] at 9:30 a.m., the DON stated the other two CMAs did have their certifications, but they were just not in the nurse aide registry. The DON stated they would get the proof from the school that tested them and provide that information.On [DATE], the facility did not provide documentation to show CMA #2 and CMA #3 had a certification to administer medications through a gastrostomy tube.

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