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	03/13/2026

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, record review, and interview, the facility failed to immediately notify the physician of a pressure ulcer for 1 (#1) of 3 sampled residents reviewed for a physician notification of a resident change in condition. The administrator identified 48 residents resided in the facility. Findings: On 03/10/26 at 11:55 a.m., the ADON was observed to provide wound care for Resident #1. The resident had a pressure ulcer to the coccyx area. Resident #1 was observed to be lying on an air mattress. An undated Notification of Changes policy, read in part, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.Circumstances requiring notification include: .Circumstances that require a need to alter treatment. A progress note, dated 11/27/25, showed a weekly nursing evaluation. The evaluation showed Resident #1's skin was warm and dry, skin color was normal, and skin turgor was normal. An admission assessment, dated 12/02/25, showed the resident was severely impaired for daily decision making. The assessment showed the resident had diagnoses which included respiratory failure, tracheostomy status, parkinsonism, gastrostomy status, coronary artery disease, and renal insufficiency. The assessment showed Resident #1 was dependent for rolling from left to right. The assessment showed Resident #1 was at risk for developing a pressure ulcer. The assessment showed Resident #1 did not currently have a pressure ulcer. A nurse progress note, dated 12/06/25, showed Resident #1 had a new pressure ulcer to the left gluteus. The note showed the pressure ulcer was in house acquired, a stage 2 pressure ulcer, and was staged by in house nursing. The progress note showed the pressure ulcer had exposed dermis and measured 3.15 cm X 0.94 cm X 0 cm. The note showed the family, physician, and wound nurse were notified. An unsigned physician order, dated 12/07/25, showed the staff was to apply Mesitran Soft Wound External Gel (a wound dressing) to the left inner buttock topically in the morning, clean with wound wash, and pat dry. Apply medi-honey (a wound medication) to left inner buttock wound, cover with a dressing daily, and change as needed or when soiled. The treatment administration record for December 2025, showed Resident #1 received wound care as ordered. A wound care clinical schedule provided by the DON, dated 12/12/25, did not show Resident #1 was to be seen by the wound care company. The DON stated they did not usually keep the lists provided to the wound care company. The DON stated they did not know why Resident #1 was not listed to be seen by the wound care company. A history and physical form, dated 12/19/25, showed an initial assessment was completed by the nurse practitioner for the wound care company for Resident #1's pressure ulcer on the buttock. The form showed Resident #1's wounds had been present for five days and was unable to determine if the pressure ulcer was getting better or worse. The assessment classified the pressure ulcer as unstageable. The form showed the pressure ulcer to the buttock measured 2.54 cm X 5.23 cm X 0.4 cm. A nursing skin evaluation, dated 12/22/25 at 2:21 p.m., showed Resident #1 had a new skin issue to the left ankle. The skin evaluation showed the resident had an unstageable pressure ulcer to the left ankle that was acquired in house. A progress note, dated 12/22/25 at 10:23 p.m., showed Resident #1 was sent by the physician to the emergency room with a blood pressure of 106/59, heart rate 118, and a temperature of 100.0 F. A (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Actual harm Residents Affected - Few	hospital after visit summary, dated 12/23/25 -12/30/25, showed Resident #1 was hospitalized for a sacral decubitus ulcer stage 4, severe sepsis, fever, elevated white blood cell count, chronic respiratory failure, and aspiration pneumonia. A wound care company progress note, dated 02/12/26, showed Resident #1 had a stage 2 pressure ulcer to the left lateral ankle that was first noted on 01/29/26. On 03/11/26 at 12:00 p.m., the physician #1 stated they did not treat pressure ulcer/wound for the residents. The physician stated the facility had a wound care company who managed the resident wounds. The physician stated they did not write wound care orders or assess wounds at the facility. The physician stated they did not write the order for wound care for Resident #1 on 12/07/25. The physician stated if there was an order for wound care they did not write it. The physician stated the wound care physician might have given the wound care order. On 03/11/26 at 3:00 p.m., the ADON stated the wound care order for Resident #1 obtained on 12/07/25 was not signed by the physician. The ADON stated they did not recall who gave the order or how the order was received. On 03/11/26 at 4:17 p.m., the nurse practitioner #1 for the wound care company stated they treated resident wounds in the facility once a week. The nurse practitioner stated they assessed and treated Resident #1's pressure ulcer to the buttock on 12/19/25. The nurse practitioner did not recall prior notification regarding a pressure ulcer for Resident #1 prior to 12/19/25. On 03/12/26 at 8:48 a.m., the DON stated the wound care company was notified of residents who needed wound care by a list provided when the wound care company entered the facility weekly. The DON stated the list was usually completed by the administrator, ADON, or themself. The DON stated anyone could add a resident name to the list if a resident needed wound care. On 03/12/26 at 3:15 p.m., the ADON stated they did not notify the physician of Resident #1's wound. The ADON stated they were familiar with treatment the wound company used and thought they wound sign the order. The ADON stated writing orders was out of their scope of practice.

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(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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to prevent the development/worsening of pressure ulcers for 1 (#1) of 3 sampled residents reviewed for pressure ulcers. The ADON identified eight residents who currently had pressure ulcers. Findings: On 03/10/26 at 11:55 a.m., the ADON was observed to provide wound care for Resident #1. The resident had a pressure ulcer to the coccyx area. Resident #1 was observed to be lying on an air mattress. An undated Wound Treatment Management policy, read in part, Wound treatment will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes. The baseline care plan, dated 11/21/25, showed Resident #1 currently had skin integrity issues. The care plan showed the staff was to apply zinc cream to Resident #1's bottom twice a day for prevention of skin breakdown. A nursing progress note, dated 11/27/25, showed a weekly evaluation. The evaluation showed Resident #1's skin was warm and dry, skin color was normal, and skin turgor was normal. An admission assessment, dated 12/02/25, showed the resident was severely impaired for daily decision making. The assessment showed the resident had diagnoses which included respiratory failure, tracheostomy status, parkinsonism, gastrostomy status, coronary artery disease, and renal insufficiency. The assessment showed Resident #1 was dependent on rolling from left to right. The assessment showed Resident #1 was at risk for developing a pressure ulcer. The assessment showed Resident #1 did not currently have a pressure ulcer. A nurse progress note, dated 12/06/25, showed Resident #1 had a new pressure ulcer to the left gluteus. The note showed the pressure ulcer was in house acquired, a stage 2 pressure ulcer, and was staged by in house nursing. The progress note showed the pressure ulcer had exposed dermis and measured 3.15 cm X 0.94 cm X 0 cm. The note showed the family, physician, and wound nurse were notified. An unsigned physician order, dated 12/07/25, showed the staff was to apply Mesitran Soft Wound External Gel (a wound dressing) to the left inner buttock topically in the morning, clean with wound wash, and pat dry. Apply medi-honey (a wound medication) to left inner buttock wound, cover with a dressing daily, and change as needed or when soiled. A care plan, dated 12/09/25, showed Resident #1 had impaired skin integrity. Interventions were to use positional devices to keep boney prominences from direct contact with each other, place therapeutic air mattress on bed, and monitor skin integrity every shift for breakdown and notify the physician for treatment orders. On 12/09/25 the intervention was to continue every hour turning schedule. A nursing skin evaluation, dated 12/22/25 at 2:21 p.m., showed Resident #1 had a new skin issue to the left ankle. The skin evaluation showed the resident had an unstageable pressure ulcer to the left ankle that was acquired in house. A progress note, dated 12/22/25 at 10:23 p.m., showed Resident #1 was sent by the physician to the emergency room with a blood pressure of 106/59, heart rate 118, and a temperature of 100.0 F. The treatment administration record for 12/2025, showed Resident #1 received wound care as ordered. A wound care clinical schedule, dated 12/12/25, did not show Resident #1 was seen by the wound care company. A physician order, dated 12/15/25, showed the staff was to apply Mesitran Soft Wound External Gel (wound dressing) to the left inner buttock topically two times a day, clean with wound wash, and pat dry. The staff was to apply medi-honey (a wound medication) and calcium alginate (a wound medication) to Resident #1's left inner buttock wound twice a day, cover with a dressing, and change the dressing as needed or when soiled. A history and physical form, dated 12/19/25, showed an initial assessment was completed by the nurse practitioner for the wound care company for Resident #1's pressure ulcer on the buttock. The form showed Resident #1's wounds had been present for five days and was unable to determine if the pressure ulcer was getting better or worse. The assessment classified the pressure ulcer as unstageable. The form showed the pressure ulcer to the buttock measured 2.54 cm X 5.23 cm X 0.4 cm. A nursing skin evaluation, dated 12/22/25 at 2:21 p.m., showed Resident #1 had a new skin issue to the left ankle. The skin evaluation showed the resident had an unstageable pressure ulcer to the left ankle that was acquired in house. A progress (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	note, dated 12/22/25 at 10:23 p.m., showed Resident #1 was sent by the physician to the emergency room with a blood pressure of 106/59, heart rate 118, and a temperature of 100.0 F. A physician order, dated 12/22/25, showed the resident was to be turned every hour from left to right only. A progress note, dated 12/22/25, showed Resident #1 was sent by the physician to the emergency room with a blood pressure of 106/59, heart rate 118, and a temperature of 100.0 F. A hospital after visit summary, dated 12/23/25 -12/30/25, showed Resident #1 was hospitalized for a sacral decubitus ulcer stage 4, severe sepsis, fever, sepsis, elevated white blood cell count, chronic respiratory failure, and aspiration pneumonia. The hospital visit summary showed Resident #1 was discharged with an open wound to the left ankle and with wound care orders. A nurse note, dated 12/30/25, showed the resident returned to the facility with an order for Metroailazole (an antibiotic medication) 500mg tablet enterally every eight hours for 10 days for a wound infection. The task tab in the electronic health record for 01/26 and 02/26, showed the Resident #1 was not repositioned every hour per the physician orders. A wound care company progress note, dated 02/12/26, showed Resident #1 had a stage 2 pressure ulcer to the left lateral ankle that was first noted on 01/29/26. The progress note showed the treatment was to cleanse the wound with cleaner, apply honey and silver alginate, and cover with a dressing every other day and as needed. On 03/10/26 at 3:19 p.m., CNA #2 stated to prevent pressure ulcers for Resident #1 they were to reposition the resident every hour. The CNA could not recall other interventions. The CNA stated the task tab in the electronic health record was were documentation for repositioning Resident #1 every hour was located. On 03/11/26 at 12:00 p.m., the physician #1 stated they did not treat pressure ulcer/wound for the residents. The physician stated the facility had a wound care company who managed the resident wounds. The physician stated they did not write wound care orders or assess wounds at the facility. The physician stated they did not write the order for wound care for Resident #1 on 12/07/25. The physician stated if there was an order for wound care they did not write it. The physician stated the wound care physician might have given the wound care order. On 03/11/26 at 4:17 p.m., the nurse practitioner #1 for the wound care company stated they treated resident wounds in the facility once a week. The nurse practitioner stated they assessed and treated Resident #1's pressure ucler on 12/19/25. The nurse practitioner did not recall prior notification regarding pressure ulcers for Resident #1. On 03/12/26 at 8:48 a.m., the DON stated the wound care company was notified of residents who needed wound care by a list provided when the wound care company entered the facility weekly. The DON stated the list was usually completed by the administrator, ADON, or themself. The DON stated anyone could add a resident name to the list if a resident needed wound care. On 03/12/26 at 9:30 a.m., the DON reviewed the documentation regarding Resident #1 being turned and repositioned every hour. The DON stated per documentation the resident was not turned and repositioned every hour. On 03/12/26 at 12:00 p.m., the DON stated the wound care company was in the facility on 12/05/25, 12/12/25, and 12/19/25 for wound care. The DON stated Resident #1's pressure ulcer was identified on 12/06/26. The DON stated they did not know why the wound care company did not treat Resident #1's pressure ulcer when in the facility on 12/12/25. The DON stated Resident #1's pressure ulcer was treated on 12/19/25 by the wound care company.