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	04/29/2026

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 0686 Level of Harm - Minimal harm or potential for 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 perform pressure ulcer care in a manner to prevent infection for 1 (#3) of 5 sampled residents reviewed for pressure ulcer care. A weekly wound flow sheet, dated 04/15/26, showed 11 residents with pressure ulcers. Findings:On 04/29/26 at 2:10 p.m., LPN #1 donned gloves and gown and entered Resident #3's room to provide pressure ulcer care. LPN #1 was observed to push personal items to one side and place two plastic trash bags on Resident #3's overbed table, next to the resident's personal items. LPN #1 did not sanitize the resident's overbed table prior to placing their dressing change supplies, bags, and gloves on the overbed table. CNA #1 and LPN #1 stepped to each side of the bed and positioned Resident #3 onto their right side. LPN #1 used their gloved hand to wipe feces from the Resident #3's upper left leg and buttock. LPN #1 then stepped back, and CNA #2 stepped to the side of the bed and provided incontinent care. CNA #1 and CNA #2 provided incontinent care, removed the soiled cloth bed pad, and placed a clean cloth bed pad under the resident. CNA #1 did not change gloves after wiping feces from the resident and before placing the clean cloth bed pad under the resident. Resident #3 was rolled from their left side and to their right side on the clean bed pad. After CNA #1 and CNA #2 repositioned Resident #3 onto their right side for pressure ulcer care, feces was still observed on the legs and buttocks of Resident #3. Wearing the same gloves, they had used to wipe feces from Resident #3's leg, LPN #1 was observed to cluster Resident #3's personal items together on the overed table, hand the oral suction yankauer to the resident, and to turn the portable suction machine on to suction. LPN #1 was observed to check the dressing supplies and to soak gauze in a cup of clear sound cleanser solution. Wearing the same gloves they used for incontinent care, LPN #1 obtained wet gauze from the cup of with their gloved fingers and used the soaked gauze to clean the remaining feces from Resident #3's legs and buttocks. LPN #1 then removed the old dressing cover and packing from the wound. Some of the packing was observed to have fallen onto the cloth bed pad. CNA #1 was observed to release Resident #3 which allowed the resident to make contact with the cloth bed pad/pillow with their back and buttocks. The contact occurred after the wound had been cleansed and application of medication had been applied but before the absorbent dressing cover was applied. Wearing the same gloves they used for incontinent care, LPN #1 cleaned the pressure ulcer. LPN #1 was observed to stick three fingers of their gloved hand into a plastic cup filled with a white paste and use their gloved fingers to apply the paste to the wound bed. LPN #1 doffed gloves and tossed them into the plastic trash bag on the overbed table. LPN #1 did not sanitize their hands before donning another set of gloves they had stored on the overbed table. LPN #1 applied the calcium alginate to the wound with their gloved fingers and then pulled open each pocket for CNA #2 to find keys to the dressing cart to obtain the absorbent dressing. LPN #1 was then observed to cover the wound with an absorbent dressing and secure with tape. On 04/29/26 at 3:00 p.m., LPN #1 stated the nurses assigned to work the floor were responsible for performing wound dressing changes. LPN #1 stated they felt nervous during the dressing change and could not remember the steps they needed to perform. LPN #1 stated they potentially contaminated their gloves when they wiped feces from the resident's left leg and potentially contaminated the resident's ventilation circuit, yankauer, suction, personal items on the overbed table, and wound care supplies having touched them with the (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

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	04/29/2026

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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 - Minimal harm or potential for actual harm Residents Affected - Few	potentially soiled gloves. LPN #1 stated since the resident still had feces on them when they were turned and positioned on the new cloth bed pad, the new bed pad became dirty and soiled. LPN #1 stated they contaminated their gloves when they used wet gauze to wipe feces from the resident before initiating the dressing change. LPN #1 stated they should have changed their gloves and the bed pad. LPN #1 stated they contaminated the wound bed when they used their gloved fingers to apply the collagen which they soaked in saline to make the paste. LPN #1 stated they should have used a tongue blade or applicator to apply the paste to the wound bed. LPN #1 stated they did not recognize Resident #3 was rolling back onto the soiled cloth bed pad between each step of the dressing change. LPN #1 stated the open pressure ulcer touching the bed pad could have potentially contaminated the ulcer. On 04/29/26 at 3:50 p.m., the DON was informed of the wound care observation. The DON stated they needed to provide their staff with more training and skills checks. On 04/29/26 at 4:30 p.m., Nurse Practitioner #1 stated the company they worked for provided wound care management to the facility residents. Nurse Practitioner #1 stated they had concerns with the dressing change the surveyor described to them. Nurse Practitioner #1 confirmed the DON was aware of the observation and stated they had training material which would be available to the DON and facility.

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, the facility failed to update the facility assessment as the acuity level of resident care increased. The DON identified 36 residents resided in the facility. Findings: A facility assessment, dated 10/15/25, read in part, Nursing facilities will conduct, document, and review a facility-wide assessment, which includes both their resident population and the resources that facility needs to care for their residents (42CFR SS483.71). The assessment will be reviewed annually and updated as needed.The purpose of the assessment is to evaluate the resident population and determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Use this assessment to make decisions about your direct care staff needs (including those who provide services under contract and volunteers), as well as your ability to provide services to the residents in your facility, at least annually and as necessary, for the above requirement. Using evidence-based, data driven methods focus on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practical physical, mental, and psychosocial well-being.The Facility assessment should drive staffing decisions and other resources and may include the operating budget necessary to carry out facility functions.A facility assessment, dated 10/15/25, showed one registered nurse needed for one day time shift per week (including weekends). The facility assessment showed a total of 10 licensed practical nurses were projected to be needed to provide care in a 24-hour period. The facility assessment showed seven licensed practical nurses were needed for the day shift, five licensed practical nurses for the evening shift, and four licensed practical nurses for the night shift. On 04/29/26 at 3:50 p.m., the DON stated the projected ten licensed practical nurses was not correct. The DON stated the DON (RN), assistant director of nursing (RN), and the minimum data set coordinator (LPN) were available to assist with resident needs during business hours, five days a week. The DON stated they assigned two LPNs to work the floor from 7a to 7p, and another two LPNs assigned to work the floor from 7p to 7a. The DON counted the number of licensed staff members available and stated there were seven licensed staff members available. The DON stated the acuity level of the residents was higher now than in October 2025 when the facility assessment was completed and they needed more staff to work directly with the residents.