

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/03/2026
NAME OF PROVIDER OR SUPPLIER  Woodview Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  1630 3rd Avenue Northeast Ardmore, OK 73401	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was free from abuse for 1 (#1) of 4 sampled residents reviewed for abuse. The administrator identified 40 residents resided in the facility. Findings: 1. On 02/02/26 at 11:00 a.m., Resident #1 was observed being assisted to the restroom by staff. On 02/02/26 at 11:35 a.m., Resident #1 was observed sitting in the common area in front of the nurses' station smiling and waving at the surveyor. A quarterly assessment for Resident #1, dated 11/05/25, showed the resident had diagnoses which included down syndrome and cerebral infarction. The assessment showed Resident #1 had a BIMS score of 02, which indicated they were severely cognitively impaired for daily decision making and required partial to moderate assistance with all activities of daily living except eating. A late entry nursing progress note for Resident #1, dated 01/26/26 at 8:09 p.m., showed on 01/25/26 at 8:00 p.m., Resident #1 came to the nursing staff and gestured to their breast and pointed to Resident #2 saying they had grabbed their breast. An initial incident report form, dated 01/26/26, showed the charge nurse reported to the DON Resident #1 communicated their breast was touched by Resident #2. The report showed staff immediately separated the two residents and no injuries were noted for either resident. The report showed supervision was initiated for Resident #2. The report showed staff in-service regarding abuse prevention and reporting was initiated and psychiatric care referrals were initiated. 2. On 02/02/26 at 10:00 a.m., Resident #2 was observed being provided one-on-one supervision by the staff with no further incidents. A significant change assessment for Resident #2, dated 11/11/25, showed the resident had a BIMS score of 12, which indicated moderate cognitive impairment. The assessment showed diagnoses which included congestive heart failure, end stage renal disease, and diabetes mellitus. The assessment showed Resident #2 required set-up assistance for oral hygiene, toileting, showering, and partial to moderate assistance with personal hygiene. A care plan for Resident #2, dated 01/25/26, showed a problem of behavioral symptoms with a history of socially inappropriate and/or disruptive behavior. The goal was the resident was to remain free from exhibiting socially inappropriate and/or disruptive behaviors with some of the following approaches listed: administer medications as prescribed, allow distance in seating other residents, allow resident to have control over situations, and if possible, assess whether the behavior endangers the resident and/or others. Intervene to ensure all residents feel safe as necessary. Physician orders for Resident #2, dated 01/26/26, showed the resident was newly prescribed Provera (hormonal medication) 10 mg once a day and Paxil (an antidepressant) 30 mg once a day. A RE 1 on 1 sitting schedule form, dated 01/26/26 through 02/02/26, showed Resident #2 was provided on-on-one supervision each shift. A quality assurance form, dated 01/26/26, showed facility department heads, corporate staff, physician, and nurse practitioner had met to develop a plan to ensure the abuse would not happen again. The form showed safe surveys were done, psychiatric consults were completed, trauma informed care observations were initiated, progress notes were written, staff interviews were conducted, full body assessments were done,</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 375393
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>care plans were updated, and in-service of staff was completed. An in-service form reviewed, dated 01/26/26, showed all staff had been in-serviced on abuse by them signing the form. Safe Surveys reviewed, dated 01/26/26, showed residents were interviewed regarding abuse. The surveys showed residents were not abused. A final incident report form, received by OSDH on 01/30/26 at 8:28 p.m., showed the facility cameras were reviewed and the footage showed Resident #2 pulling their wheelchair beside Resident #1, lifting Resident #1's blanket and putting their hand on Resident #1's breast. The report showed the physician, law enforcement, and family were immediately notified. The report showed other residents were interviewed and not found to have experienced any abuse. The report showed Resident #2 continued to be supervised and was seen by a psychiatrist and medications adjustments were made. The report showed Resident #1 had no residual effects from the incident. The report showed Resident #2 had referrals sent to multiple inpatient psychiatric facilities but had been denied. The report showed Resident #2 would continue to be supervised, psychiatric consultations as needed, and provided additional interventions as needed. On 02/02/26 at 10:00 a.m., the DON was interviewed and reported other facilities had been sought out to transfer Resident #2 to. The DON stated due to Resident #2 having dialysis three times weekly, all the facilities that had been contacted had refused Resident #2. The DON stated Resident #2 had no behaviors before or since the incident with Resident #1. The DON stated Resident #2 remained on one-on-one with staff. On 02/03/26 at 9:40 a.m., CNA #3 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:43 a.m., licensed practical nurse #1 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:45 a.m., registered nurse #1 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:50 a.m., housekeeper #1 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:52 a.m., CNA #4 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:55 a.m., CNA #5 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:59 a.m., CNA #6 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 11:15 a.m., the administrator stated Resident #1 and Resident #2 were immediately separated after the incident on 01/25/26 and an investigation began. They stated Resident #2 was placed on one-on-one with staff.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to report allegations of abuse to OSDH within two hours for 2 (#1 and #3) of 4 sampled residents reviewed for abuse. The administrator identified 40 residents resided in the facility. Findings: An Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, dated September 2022, read in part, Reporting Allegations to the Administrator and Authorities.3. 'immediately' is defined as: a. within two hours of an allegation involving abuse. 1. An initial incident report form, dated 06/11/25, showed Resident #3 had a diagnosis of severe dementia and they ambulated independently. The report, read in part, This morning [CNA #1] reported to the DON that they had observed [CNA #2] scream at [Resident #3] in the dining room yesterday evening. The facsimile receipt showed OSDH received the incident report on 06/12/25 at 4:41 p.m.2. A late entry nursing progress note for Resident #1, dated 01/26/26 at 8:09 p.m., showed on 01/25/26 at 8:00 p.m., Resident #1 came to the nursing staff and gestured to their breast and pointed to Resident #2 saying they had grabbed their breast. The note showed Resident #1 gestured they slapped the hand of Resident #2. The note did not show the allegation had been reported to the abuse coordinator. An initial incident report form, dated 01/25/26, showed the charge nurse reported to the DON and administrator Resident #1 communicated that their breast was touched by Resident #2. The facsimile received by OSDH was dated 01/26/26 at 2:55 p.m. On 02/03/26 at 11:30 a.m., the administrator nodded and was in agreement the allegations of abuse were not reported to OSDH timely.</p>		