

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Westhaven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 South Western Stillwater, OK 74074	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff implemented proper infection control practices after performing incontinent care for 1 (#10) of 2 sampled residents observed for incontinent care.</p> <p>The director of nursing identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>On 06/18/25 at 1:33 p.m., CNA #1 and #2 were observed to enter Resident #10's room to provide incontinent care. CNA #2 explained each step to Resident #10 as they performed the incontinent care. CNA #1 removed blankets from Resident #10 and then removed the pillow from under the resident's legs. CNA #1 was observed to assist Resident #10 to their right side, wipe their peri area with four wipes using each one time and disposing of the wipe. CNA #1 then assisted Resident #10 to their back and wiped the resident's peri area with three wipes using each wipe one time. CNA #1 replaced the pillow, one by one pulled up each of the four blankets, and used a remote to raise the head of the bed. CNA #1 then placed the remote on the blankets nearest Resident #10's left arm. Once incontinent care was completed, CNA #1 did not remove their soiled gloves or sanitize their hands.</p> <p>A Perineal Care policy, revised February 2018, read in part, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition .Put on gloves .Remove gloves and discard into designated container .Wash and dry hands thoroughly .Reposition the bed covers.</p> <p>On 06/18/25 at 1:42 p.m., CNA #1 stated the policy for glove use for providing incontinent care was to remove the gloves before touching clean areas. CNA #1 stated they did not remove their soiled gloves prior to replacing the clean items.</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
---	-------	-----------