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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375417	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhaven Nursing Home	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an allegation of abuse was immediately reported for 1 (#1) of 3 sampled residents reviewed for abuse.The administrator identified 60 residents resided in the facility. Findings:An undated policy titled Patient Abuse, read in part, It is strictly prohibited for any employee fail to immediately report an incident of patient abuse to the Administrator, or DON.An admission assessment for Resident #1, dated 01/25/26, showed the resident's cognition was severely impaired with a BIMS score of 03. The assessment showed the resident was dependent on staff for transfers and required substantial/maximal assistance from staff for wheelchair use. The assessment showed the resident had diagnosis which included dementia.An incident report for Resident #1, dated 02/12/26, showed an allegation of abuse on 02/11/26. The report showed on 02/11/26 at approximately 11:00 p.m., RN #1 observed CNA #1 behave in an abusive manner toward Resident #1. The report showed RN #1 did not report the abuse allegation until 6:00 a.m. on 02/12/26 to the DON.On 02/18/26 at 1:21 p.m., family member #1 stated they had been called to the facility on [DATE] from approximately 10:30 p.m. to 11:00 p.m. because Resident #1 was being combative with care. Family Member #1 stated they asked for the resident to be transferred to the couch where they had been sleeping recently. Family Member #1 stated CNA #1 yanked the resident up from the wheelchair and dropped them down on the couch with force. Family Member #1 stated they felt the CNA's actions were abusive.On 02/18/26 at 1:52 p.m., RN #1 stated they had asked CNA #1 to transfer Resident #1 from the wheelchair to the couch in the common area. RN #1 stated CNA #1 was mad and aggressively transferred the resident to the couch. RN #1 stated they spoke with family member #1, and both felt the CNA's actions were abusive to the resident. RN #1 stated they were busy with their duties for their shift and did not report the incident to the DON until the next morning at 6:00 a.m.On 02/19/26 at 9:40 a.m., the administrator stated they reported the abuse allegation and started an investigation as soon as they were made aware of the incident by RN #1.On 02/19/26 at 10:30 a.m., the DON stated the incident should have been reported to them or the administrator immediately by RN #1. The DON stated RN #1 had been terminated for not reporting an allegation of abuse and CNA #1 was terminated due to their behavior.

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: 375417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to immediately protect a resident from the potential for further abuse for 1 (#1) of 3 sampled residents reviewed for abuse.The administrator identified 60 residents resided in the facility.Findings:An undated policy titled Patient Abuse, read in part, To protect the resident from employees during an abuse investigation, the employee will be suspended during the investigation process.1.An admission assessment for Resident #1, dated 01/25/26, showed the resident's cognition was severely impaired with a BIMS score of 03. The assessment showed the resident was dependent on staff for transfers and required substantial/maximal assistance from staff for wheelchair use. The assessment showed the resident had diagnosis which included dementia.An incident report for Resident #1, dated 02/12/26, showed an allegation of abuse on 02/11/26 at approximately 11:00 p.m., for CNA #1 towards Resident #1. The report showed RN #1 did not report the abuse allegation until 02/12/26 at 6:00 a.m. to the DON. The report showed CNA #1 was suspended after the abuse allegation was reported to the DON.2. A timesheet for CNA #1, dated 02/01/26 through 02/15/25, showed CNA #1's last day to work was 02/12/26. The timesheet showed CNA #1 clocked out at 6:15 a.m. on 02/12/26.On 02/18/26 at 1:52 p.m., RN #1 stated the allegation of abuse was not reported to the DON until 6:00 a.m. on 02/12/26. RN #1 stated they did not send CNA #1 home after the abusive behavior was witnessed. RN #1 stated they did not know the facility's abuse procedure and waited till the next morning to report it.On 02/19/26 at 10:30 a.m., the DON stated CNA #1 should have been sent home immediately by RN #1 while an abuse investigation was conducted. The DON stated CNA #1 should not have been allowed to finish the shift.