STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375423	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmwood Manor Nursing Home	300 South Seminole Wewoka, OK 74884

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/29/25, an immediate jeopardy (IJ) situation was determined to exist the facility failed to ensure Resident #1 was free from sexual abuse and psychosocial harm from Resident #2. The incident resulted in Resident #2 raising Resident #1 shirt up and inappropriately grabbing their breast in the front lobby.On 10/29/25 at 4:45 p.m., OSDH was notified and verified the existence of the IJ situation.On 10/29/25 at 5:25 p. m., the administrator was notified of the IJ situation and was provided the IJ template. On 10/30/25 at 10:56 a.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, Plan of Removal of IJ 10/29/202510/29/2025 [staff name withheld], General Manager completed the Process for Completion of a State Reportable given by [name withheld], [staff name withheld], Administrator has also completed training from [business name withheld] on Abuse and Neglect and from [business name withheld] on Conducting an Abuse Investigation.In-service was provided to [staff name withheld], Administrator and [staff name withheld], Corporate Nurse on Abuse investigation, Reporting, Completion, Conducting and the updated abuse policy 10/29/25.10/29/2025 All staff was educated on abuse, neglect, and exploitation by [staff name withheld], Administrator.10/29/2025 Resident #2 was educated on abuse and resident's rights by [staff name withheld].10/29/2025 All staff was educated on the reporting structure and be provided contact information for the administrator of record by [staff name withheld], Administrator.10/29/2025 Resident #2 was put on one on one monitoring with direct care staff or designee when out of resident's room for 30 days to monitor for agitation, under stimulation and overstimulation.10/29/2025 Resident #2 medications will be reviewed by Psych [staff name withheld] NP and Dr.[staff name withheld] MD, to assist with potential reduction and behaviors due to side effects if applicable.10/29/2025 All findings and audits will be reviewed the[sic] Director of Nursing, Administrator and/or designees daily for 30 days.10/29/2025 A review of residents will be done to list any [gender withheld] resident that are at risk for inappropriate unwanted behavior. This list will be done by the Director of Nursing.10/29/2025 All at risk [gender withheld] resident will be not placed near Resident #2.10/29/25 All at risk [gender withheld] residents will be care planned with interventions of maintaining placement when out of room away from resident #2.10/29/2025 All [gender withheld] at risk residents who are at risk for unwanted behavior will be added to the shift monitor report so that the charge nurse and staff are aware to maintain distance from resident #2.10/29/2025 Facility will continue to work with active family member to restructure visit times to be scheduled during high aggressive times once identified during the 30 days of monitoring.10/29/2025 Resident #1 will be monitored daily by the charge nurse for 60 days for any psychosocial alterations.10/29/2025 All staff and currently in facility residents was interviewed to rule out abuse, neglect or exploitation using a safe survey. There were no other residents affected. This was completed by [staff name withheld], Administrator.10/29/2025 The abuse, neglect and exploitation policy was updated by [staff name withheld], General Manager to include specific verbiage inappropriate sexual behaviors in the screening component, training component, prevention component and identification component.10/29/25 A QA was created and implemented pertaining to the inappropriate behaviors of Resident #2 with interventions.10/29/25 A monitoring form for interventions for resident #2 was created and implemented.10/29/2025 Education was provided to activities/social services staff to do 1:1 activities with Resident #2 after lunch. This was done by [staff name withheld], Administrator. 10/29/2025 The care plan for [resident name withheld] was updated to include the interventions put into place.10/29/2025 The care plan for [resident name withheld] was updated to include the psych-social monitoring and an order was placed in the emar to be monitored daily by nurses.10/29/2025 [resident name withheld] was seen on 10/28/2025 by [staff name withheld] NP and Dr. [staff name withheld]. [gender withheld] medication was reviewed and the Prevera [sic] was increased from 10mg to 20 mg. The diagnosis for the Prevera [sic] is SOA, which s sexually inappropriate behaviorDescription of #5 for non-verbal residents----Residents that identify as non-verbal/incapacitated were interviewed on 10/29/2025 using the following process: a direct care staff member accompanied administrator to conduct interviews. Resident are asked each question with a 2 minute timed response window time: Residents are observed for the following by both person [sic] present. Administrator and the CMA watched for facial expressions, gestures, and emotional cues/reactions also, anything noted outside of baseline is documented. A summary of the observation is recorded. Unless the responses are clear and observable, the question is not answered yes or no.Description of #9----line of sight---all staff were instructed via (elect. Inservice) to keep resident #2 away from all [gender withheld] residents who have been identified as vulnerable or at risk of inappropriate

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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 thoroughly investigate allegations of abuse for 1 (#1) of 8 residents sampled for abuse.The corporate nurse identified 39 residents resided in the facility. Findings: A facility policy titled, Abuse Investigations, revised October 2009, read in part, All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation will, as a minimum: Interview any witnesses to the incident; .Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . Interview the resident's roommate, family members, and visitors; .Review all events leading up to the alleged incident.5. Witness reports will be obtained in writing. Witness will be required to sign and date such reports.An incident report dated of 10/14/25, showed [Resident #2] was inappropriately touching [Resident #1] and had [Resident #1's] shirt up and touching their breast.On 10/29/25 at 1:35 p.m., the general manager was asked if the10/14/25 allegation abuse witness statements were completed. They stated I should have done a full investigation for 10/14/25 abuse incident.On 10/29/25 at 2:04 p.m., the administrator stated they had no witness statements from the 10/14/25 incident of abuse on Resident #1 and Resident #2.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], an IJ situation was determined to exist when the facility failed to ensure Resident #8 was monitored and received assistance while eating in their room. The incident resulted in the death of Resident #8. Resident #8 had a care plan intervention which included assist to dine.On [DATE] at 1:00 p.m., the OSDH was notified and verified the existence of the IJ situation.On [DATE] at 1:30 p.m., the administrator was notified of the IJ situation and was provided the IJ template.On [DATE] at 10:55 a.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, POR [DATE] for IJ cited on [DATE] @ [at] 1:30pmSummarized Statement of Deficiency (Problem Identified):Staff failed to provide required meal supervision for a resident with two prior choking incidents and an established care plan requiring Immediate Removal Actions Taken:All residents nutritional care plans and diets were reviewed for choking risk, non-compliance with diets, therapeutic diets, and assisted feeding needs on [DATE]. 2 Residents that are at risk of choking or non-compliance with diet orders/ diet recommendations or residents who require assistance with feeding were identified on [DATE].4 Residents were identified as a choking risk4 Residents were identified that require feeding assistance5 were identified as non-complaint 3. All residents that had a therapeutic diet were identified on [DATE] residents were identified as having therapeutic diets 4. All residents identified as choking risk received nutritional care plan update by Clinical staff on [DATE] Residents were identified and received nutritional care plan updates 5. A quick reference chart (diet reference list) was created on [DATE] for all clinical staff and dietary staff to utilize, the chart includes:The resident's meal location(s) preference, the resident's diet (including consistency), portion, and protein supplements to be added to meals The quick reference chart was placed at the nurse's station in the nurse shift book on [DATE]The quick reference chart was placed in the kitchen on the bulletin board on [DATE]The quick reference chart was placed at the nurse's station in the cna shift report book on [DATE] 6. On [DATE] a policy addendum on choking or dietary non-compliance was created and added to the assistance with meals policy, to reflect the following changes and implemented:Key personnel to contact regarding a choking or dietary non compliance event to allow early interventionKey personnel to contact regarding residents who are non-compliant with diet and dietary interventions Assessment of the resident to determine the need for treatment such as the Heimlich 7. On [DATE] CPR policy and procedure was created and implemented to reflect the following changes: When to initiate CPR Training and competency -All clinical staff must maintain valid CPR/BLS certification. -Newly hired staff are required to obtained[sic] CPR certification within 90 days of hire -CPR recertification is required every 2 years - A 45 day grace period is permitted for staff to renew an expired certification - proof of certification shall be maintained in personnel files 8. [DATE] and [DATE] Inservice educations were provided, completed, and implemented to all clinical staff by the administrator, Director of nursing, and Corporate nurse on the following topics:Topic: Supervision during meals plans -all clinical staff were educated on procedures for meals supervision. Staff will stay with resident 1:1 until entire meal is completed during any mealtimes for all residents who require feeding assistance or are choking risk. Trainers: administrator, Director of nursing, and Corporate nurse (completed on [DATE])how to locate/follow care plan-all clinical staff were in serviced where to locate the residents care plan in the resident's electronic health record. Staff were also educated if they cannot access the information needed in the care plan, they are to notify the charge nurse, and he/she will retrieve the information. Trainers: Administration, Director of nursing, and Corporate nurse (completed on [DATE])Procedure related to a choking event- all clinical staff and dietary supervisor were educated on who were choking risk, who to report choking events to, and how to report dietary compliance issues. Trainers: Administrator, Director of nursing, and Corporate nurse (completed on [DATE])CPR and Heimlich- all clinical staff were CPR trained on [DATE] unless training had been provided prior. Trainers: Administrator, Director of nursing, and Corporate nurse (completed on [DATE]) 9. Quality Assurance PIP was conducted and completed on [DATE] to address assisting and monitoring residents named as choking risk and 1:1 supervision of residents during mealtimes until meal is completed. 10. Quality assurance monitoring was created and implemented on [DATE].Monitoring will be completed for Resident at risk for choking by DON/Designee 3 times weekly for 90 days and as needed thereafter. The IJ was lifted effective [DATE] at 2:53 p.m., when all the components of the POR had been verified as completed.a. all clinical staff were interviewed and were able to communicate regarding services for care plans, non-compliance, therapeutic diets, and assisted feeding needs in-service that was conducted on

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview, the facility failed to ensure 1 of 1 treatment cart was locked when not in use.The corporate nurse identified 39 residents resided in the facility and had one treatment cart.Findings:On 11/03/25 at 2:39 p.m., the treatment cart was observed [NAME] of the nurse's station unlocked and unsupervised with insulin pens and vials in the top drawer.On 11/03/25 at 2:40 p.m., LPN #1 was observed walking to the South end of the hallway and away from the treatment cart.On 11/06/25 at 1:29 p.m., the treatment cart was observed [NAME] of the nurse's station unlocked and unsupervised.On 11/06/25 at 1:30 p.m., LPN #2 was observed standing in dining hall out sight of the treatment cart, which was unlocked and unsupervised.A policy titled Security of Medication Cart, revised April 2007, read in part, 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 4. Medication carts must be securely locked at all times when out of the nurse's view.On 11/04/25 at 2:41 p.m. LPN #1 stated the treatment cart was unlocked and unsupervised. LPN #1 stated it was their responsibility to ensure the treatment cart was locked.On 11/04/25 2:45p.m., the corporate nurse stated the facility had two medication carts and one treatment cart that sat by the nurse's station. On 11/04/24 at 3:11 p.m., the corporate nurse was asked what items were stored in the treatment cart. They stated the treatment cart contained insulin and peg tube supplies.On 11/06/25 at 1:31 p.m., LPN #2 stated they were supposed to supervise the treatment cart and lock it.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, the facility failed to track and monitor choking incidents for 1 (#8) of 3 sampled residents reviewed for choking incidents for quality assurance.The corporate nurse identified 39 residents resided in the facility.Findings:A policy titled Safety and Supervision of Residents, revised December 2007, read in part, QA & A reviews of safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization.A nursing note for Resident #8, dated 01/18/24, read in part, called to residents room D/T [due to] resident choaking [sic], . At 5:50 p.m. Paramedic staff pronounced time of death.The quality assurance notes, dated 02/29/24, did not show any documentation for monitoring and tracking related to Resident #8's choking incident on 01/18/24 which resulted in Resident #8's death in the facility.On 11/04/25 at 1:07 p.m., the corporate nurse stated they did not QA or document the 01/18/24 incident involving Resident #8.