STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375431	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Health Care Center	7019 Northwest Cache Road Lawton, OK 73505

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate assistance to prevent a lift accident for 1 (#3) of 3 residents reviewed for accidents. The administrator reported 78 residents resided at the facility. Findings: On 05/28/25 at 11:07 a.m., Resident #3 was observed in their room sitting in their wheelchair. A policy Lifting Machine, Using a Portable, dated December 2013, showed the purpose of the procedure was to help lift residents using a manual lifting device. The policy showed two nursing assistants were required to perform the procedure. A quarterly assessment, dated 02/13/25, showed Resident #3 was moderately impaired with cognition. The assessment showed the resident was dependent on staff for assistance with activities of daily living. The assessment showed the resident had diagnoses which included multiple sclerosis, paralytic syndrome, lack of coordination, and tremors. A progress note, dated 04/17/25 at 5:07 p.m., showed ADON #1 responded to an incident with Resident #3. The note showed the resident was assessed while still on the floor after the lift tilted while staff was transferring the resident. The note showed Resident #3 did not feel the staff member was at fault but needed additional education on transferring with the lift. The note showed a family member had viewed camera footage and reported the resident did not fall hard and could see the staff member lower the resident to the floor. On 05/28/25 at 11:10 a.m., Resident #3 reported there had been one incident when the lift tipped over and fell on them. The resident reported they were not injured and were not afraid of the lift. On 05/28/25 at 1:17 p.m., CNA #1 reported it was standard procedure and facility policy to have two people use the lift when transferring residents. On 05/28/25 at 1:25 p.m., LPN #1 reported it was standard practice to have two people when using the lift while providing care to residents. On 05/28/25 at 1:40 p.m., RN #1 reported the facility had a few residents who required the lift and it was always a two-person assist. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/29/25 at 7:07 a.m., CNA #2 reported they couldn't remember the name of the aide who used the lift without a second person assist, but CNA #2 was called in to replace the aide when they were suspended after the incident with Resident #3. CNA #2 reported lifts were always used with two people. On 05/29/25 at 8:15 a.m., ADON #1 reported CNA #3 came and got them to let them know Resident #3 was on the floor after the lift tilted. The ADON reported CNA #3 was able to lower the resident to the floor without injury. The ADON was asked if CNA #3 reported why they did not have a second person assisting. The ADON reported they thought the resident was in a hurry to get up so the aide did not wait for assist. The ADON reported there was plenty of staff available the day of the incident and there was no reason the aide could not get assistance with transferring the resident. On 05/29/25 at 9:44 a.m., CNA #3 was interviewed by phone. CNA #3 reported on the day of the incident, Resident #3 wanted to get up for a smoke break and was in a hurry. CNA #3 reported they knew they should have gotten a second person to assist with the lift but did not take the time to get someone to help.