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	10/07/2024

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30875 Based on record review and interview, the facility failed to ensure advance directive acknowledgement forms were completed for two (#10 and #24) of 18 sampled residents reviewed for advance directives. Findings: The administrator identified 78 residents resided in the facility. The Advance Directives policy, dated December 2016, read in part, Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directive. 1. Resident #10 was admitted to the facility on [DATE] with a re-entry date of 09/15/24. A physician order, dated 06/15/23, documented full code. Full code was marked in the electronic record. No acknowledgement form for an advance directive was in the clinical record or electronic record. 2. Resident #24 was admitted to the facility on [DATE]. A physician order, dated 05/29/24, documented full code. Full code was marked in the electronic record. No acknowledgement form for an advance directive was in the clinical record or electronic record. On 10/01/24 at 3:15 p.m., the administrator was asked the reason the advance directive acknowledgements were completed for Residents #10 and Resident #24 during the current survey. They reported the acknowledgement forms were part of the admission packet, but at this time the forms were not being completed.

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 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. 41873 Based on record review and interview, the facility failed to ensure an allegation of neglect was reported to the State Agency (OSDH) for one (#38) of one sampled resident reviewed for abuse. The administrator identified 78 residents resided in the facility. Findings: Resident #38 had diagnoses which included hemiplegia. A comprehensive assessment, dated 07/18/24, documented Resident #38's cognition was impaired and was dependent on staff to complete activities of daily living. An incident report form ODH Form 283, dated 09/03/24, documented an allegation of neglect involving Resident #38. The incident report documented notifications made to the following: physician, family, local law enforcement, and nurse aide registry. The incident report documented no proof of the fax transmission. On 10/03/24 at 9:37 a.m., the OSDH complaint department confirmed no incident reports had been received from the facility since 06/18/24. On 10/03/24 at 10:00 a.m., the administrator provided an email confirmation submitted to the OSDH on 09/09/24 at 12:57 p.m. The administrator reported the email confirmation documented no proof the fax transmission was received by OSDH.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on record review and interview, the facility failed to refer residents with newly diagnosed mental illnesses to the OHCA for a Level II PASARR evaluation for three (#9, 38, and #60) of three sampled residents reviewed for PASARRs. The administrator identified 78 residents resided in the facility. Findings: An undated Resident Assessment - Coordination with PASARR Program policy, read in part, Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review . 1. Resident #9 was admitted to the facility on [DATE]. The Level I PASARR screen, dated 09/06/07, documented no mental illness. On 11/20/14, the resident was diagnosed with bipolar disorder. On 12/18/29, the resident was diagnosed with major depressive disorder and schizophrenia. 2. Resident #38 was admitted to the facility on [DATE]. The Level I PASARR screen, dated 07/24/19, documented no mental illness. On 06/06/20, the resident was diagnosed with major depressive disorder. On 09/06/20, the resident was diagnosed with mood disorder. 3. Resident #60 was admitted to the facility on [DATE]. The Level I PASARR screen, dated 10/19/22, documented no mental illness. On 11/21/22, the resident was diagnosed with schizoaffective disorder. On 11/22/22, the resident was diagnosed with mood disorder. On 10/02/24 at 3:19 p.m., the MDS coordinator reported not being aware if a residents new diagnosis of mental illness, not documented on the Level I PASARR screening at admission, had to be reported to the OHCA to evaluate the need for Level II services. They reported no PASARR policy had been received to follow for completing PASARR screenings. They reported they had only reported new mental illness if a resident had an inpatient mental hospital stay. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/03/24 at 11:28 a.m., the MDS coordinator agreed, after reading over the facility's PASARR policy Resident #9, #38, and #60's new diagnoses of mental illness should have been reported to the OHCA when they were newly evident.

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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 - 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. 41873 On 10/03/24, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure Resident #38, who had been assessed to require supervision and a smoking apron when smoking, was provided adequate supervision. A care plan intervention, updated 01/31/24, documented Resident #38 required staff supervision with smoking and the use of a smoking apron. A smoking assessment, dated 02/15/24, documented Resident #38 was safe for smoking with supervision and use of a smoking apron. An incident report, dated 04/19/24, documented an unwitnessed incident. The report documented Resident #38 reported, I was lighting my cigarette and my beard caught on fire. The incident report documented two small burns to the left side of the resident's face and under their left ear. A smoking assessment, dated 09/08/24, read in part, Safe for smoking with one-on-one assist and a smoking apron. On 10/03/24 at 12:41 p.m., Resident #38 was observed smoking without supervision and without a smoking apron. Cigarette ashes were observed on the resident's right thigh. On 10/03/24 at 12:55 p.m., the AIT was observed to bring Resident #38 two cigarettes and provided assistance with lighting one of the cigarettes. On 10/03/24 at 12:57 p.m., Resident #38 was observed smoking without a smoking apron. The AIT was observed providing water to other residents in the smoking area. On 10/03/24 at 1:00 p.m., the AIT reported not being aware if Resident #38 required a smoking apron and would have to check. On 10/04/24 at 1:25 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 10/04/24 at 1:35 p.m., the administrator was notified of the IJ situation. On 10/07/24 at 3:29 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal documented: The facility asserts that the likelihood of serious harm no longer exists as of 10/04/24, at 4:30 p.m. Issue Cited: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #38 had smoking assessments, dated 01/31/24 and 02/15/24, and was found to be unsafe to smoke unsupervised and required smoking interventions. Care plan interventions, dated 01/31/24 and last reviewed 07/23/24, documented resident #38 required staff supervision and the use of a smoking apron. An incident report, dated 04/19/24, documented an unwitnessed smoking incident for resident #38 where he caught his beard on fire lighting his cigarette. The incident resulted in two small burns to left side of face and under left ear. A smoking assessment, dated 09/08/24, found resident to be unsafe for smoking without one-on-one assist, supervision and a smoking apron. Staff interview reported knowledge of resident needing to be supervised with smoking but not aware if a smoking apron was required. On 10/03/24 at 12:41 p.m., resident #38 was observed smoking in the designated smoking area unsupervised and without a smoking apron in place. Identification of Residents Affected or Likely to be Affected: (Completion Date 10/03/24.) a. Resident #38 reside in the building at time of the survey b. Resident #4 [name withheld] c. Resident #33 [name withheld] d. Resident #54 [name withheld] e. Resident #30 [name withheld] Actions to Prevent Occurrence Recurrence: 1. MDS conducted a 100% audit of residents who smoke on the Smoking Safety Screen and updated resident's screen to reflect the current status. 10/04/24. 2. Social Services conducted a 100% audit on BIMS assessments for residents who smoke and updated them to reflect the current status. 10/04/24. 3. Wound Care nurse conducted a 100% skin sweep of all residents who smoke and updated the skin assessment to reflect the current status. 10/04/24. 4. The Housekeeping Supervisor conducted an inspection of resident clothing for all residents who smoke to identify need for assessment or supervision. 10/03/24. 5. The Maintenance Director inspected the facility grounds for smoking materials, smoking aprons, ashtrays, and fire extinguishers. 10/03/24. 6. The MDS Coordinator conducted a 100% audit on residents' care plans and updated them to reflect the current status. 10/03/24. 7. The Administrator attended a resident meeting to review the smoking policy with the residents. 10/04/24. 8. The Housekeeping Supervisor and Social Services conducted a room sweep of residents who are supervised smokers for lighters and smoking materials. 10/03/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. The DON and Administrator conducted a smoking in-service for all employees, which was completed on 10/04/24. Ongoing education will be provided to new staff and as needed. Conduct telephonic in-service with staff who are currently out with follow up ongoing education prior to working their assigned shift. 10. The Administrator conducted QAPI to discuss the smoking policy and procedure, completed on 10/03/24. 11. Delegated staff are assigned specific smoking times according to the smoking schedule for supervised smokers. 10/03/24. 12. The DON and/or designee will review smoking safety screening for each admission during clinical meeting and implement the appropriate interventions. 10/04/24. 13. Admissions and Social Service will review the smoking times and policy with each new admission. 10/04/24. The IJ was lifted, effective 10/07/24 at 4:39 p.m., when all components of the plan of removal had been verified as completed. The deficient practice remained at an isolated with a potential harm. Based on observation, record review, and interview, the facility failed to ensure adequate supervison was provided and a smoking apron was in place while smoking for one (#38) of three sampled residents reviewed for smoking safety. The administrator identified 78 residents resided in the facility. Findings: An undated resident smoking policy, read in part, All safe smoking measures will be documented on each resident's care plan .Supervision will be provided as indicated on each resident's care plan .Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff or designee . Resident #38 had diagnoses which included hemiplegia, seizure disorder and cerebral infraction. A smoking assessment, dated 01/31/24, read in part, Residents need for adaptive equipment: smoking apron and supervision. A smoking assessment, dated 02/15/24, read in part, Resident reassessed for smoking .Found to be safe to smoke with supervision and smoking vest .Charge nurse and staff made aware that the resident would need to be monitored while smoking and that the smoker's apron would need to be utilized. A facility incident report, dated 04/19/24, documented an unwitnessed smoking injury. The incident report documented Resident #38 reported, I was lighting my cigarette and my beard caught on fire. The incident report documented two small burns to the left side of the resident's face and under their left ear. The incident report, read in part, Area to left side of face cleansed with wound cleaner, pat dry, silvasorb applied, physician notified, resident agreed to allow staff to shave today, and two small one mm areas noted below left ear. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A smoking assessment, dated 04/24/24, read in part, Resident needs supervision when smoking and beard needs to be kept short .Resident unable to light cigarette safely and supervision required to ensure lit cigarette does not make contact with beard, hair, skin, and clothing. A comprehensive assessment, dated 07/18/24, documented Resident #38 was dependent on staff for most activities of daily living and dependent on staff to ambulate with a wheelchair. The comprehensive assessment documented the resident was unable to complete the brief interview for mental status. A care plan, last reviewed 07/23/24, read in part, I require staff supervision/adaptations when using tobacco products, revised 01/31/24. *Staff will complete a smoking assessment to ensure my safety quarterly, revised 01/31/24. *I require assistance with lighting tobacco products only, initiated 10/29/21. *I require the community to keep all tobacco and fire starting materials for, initiated 10/29/21. *I require the use of an Adaptive Device: Smokers Apron, initiated 01/31/24. *My smoking supplies are stored at the nurse's station, initiated 10/29/21. A smoking assessment, dated 09/08/24, read in part, Safe to smoke with supervision, beard must be kept short, needs one-on-one assist and a smoking apron. On 10/03/24 at 11:30 a.m., CNA #5 reported not being aware which residents required supervision with smoking. The CNA reported if a resident was required to be supervised, and an employee was available, they went out with the resident to smoke. On 10/03/24 at 12:36 p.m., Resident #38 was observed sitting in their wheelchair by the smoking area door in the common area with an unlit cigarette in their mouth waiting to go outside. On 10/03/24 at 12:41 p.m., Resident #38 was observed outside in the smoking area smoking. They were observed leaned over to the right in their wheelchair. There was no staff present in the smoking area and the resident did not have a smoking apron on. The resident was observed to have cigarette ashes on their right thigh and the cigarette was very short. The resident was observed dozing off to sleep while smoking. On 10/03/24 at 12:50 p.m., Resident #38 was observed in the smoking area and no longer smoking. The resident's head was down and sleeping. The resident reported they were okay. On 10/03/24 at 12:55 p.m., the AIT was observed to bring Resident #38 two cigarettes and provided assistance with lighting one of the cigarettes. On 10/03/24 at 12:57 p.m., Resident #38 was observed smoking without a smoking apron. The AIT was observed providing water to other residents in the smoking area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/03/24 at 1:00 p.m., the AIT reported not being aware if Resident #38 required a smoking apron and would have to check. On 10/03/24 2:22 p.m., CMA #2 reported cigarettes were kept on the medication cart. The CMA reported supervised smokers got a cigarette if they had someone to go out and smoke with them. The CMA reported they were not aware if Resident #38 required a smoking apron and was not aware where the smoking aprons were kept. On 10/03/24 2:22 p.m., CMA #3 reported they went out with supervised smokers when they were working the floor. They reported they were not sure which smokers needed an apron. The CMA stated they thought Resident #38 required an apron due to just visualizing the resident outside smoking with a smoking apron on. On 10/03/24 at 2:28 p.m., CNA #2 reported no smoking aprons had been used for smokers and was unaware where the smoking aprons were stored. On 10/03/24 at 2:36 p.m., CNA #3 reported working on both sides of the facility. They reported Resident #38 required supervision with smoking due to leaning over to the side in their wheelchair, but not a smoking apron. On 10/03/24 at 3:40 p.m. the administrator and AIT reported all staff should be aware who required smoking supervision and a smoking apron. The AIT reported three residents required supervision with smoking and a smoking apron. The administrator reported a new smoking policy was initiated, on 09/01/24 from corporate, and all staff had been in-serviced on the new policy. The AIT reported Resident #38 required a smoking apron and required supervision for smoking.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41873 Based on observation, record review, and interview, the facility failed to ensure: a. enhanced barrier precautions were implemented for two (#69 and #78) of three sampled residents observed during wound care; b. enhanced barrier precautions were implemented for one (#69) of one sampled resident observed during Foley catheter care; and c. contact precautions were implemented for one (#49) of one sampled resident observed for transmission-based precautions. The ADON #2 identified one resident required TBP. The regional consultant identified 19 residents required enhanced barrier precautions. The administrator identified 78 residents resided in the facility. Findings: An Enhanced Barrier Precautions policy, dated 04/01/24, read in part, *It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug resistant organisms. *An order for enhanced barrier precautions will be obtained for wounds and/or indwelling medical devices. *Make gowns and gloves available near or outside the resident's room. *Face protection may also be needed if performing activity with risk of splash or spray. *PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. An undated isolation policy titled Contact Precautions, read in part, *Implement contact precautions for residents known or suspected to be infection with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment *Wear gloves when entering the room. *Wear a disposable gown upon entering the contract precautions room. *The facility will implement a system to alert staff to the type of precautions resident requires. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident. 1. Resident #78 had diagnoses which included diabetes mellitus, lung cancer, and dementia. A comprehensive assessment, dated 9/13/24, documented Resident #78's cognition was severely impaired and required extensive assistance with activities of daily living. A physician's order, dated 09/18/24, read in part, Cleanse right heel with wound cleanser, pat dry, apply leptospermum honey daily x 23 days .Float/off load heels as ordered .Left side of neck cleanse with wound cleanser, apply leptospermum honey, apply alginate calcium, cover with border gauze daily x 23 days . A physician's order, dated 09/20/24, read in part, Cleanse sacrum wound with wound cleanser, pat dry, apply alginate calcium, apply island gauze cover with boarder dressing daily x 30 days. On 09/30/24 at 11:25 a.m., the wound care nurse and wound physician removed the resident's wound dressing to coccyx, right heel, and left side of their neck. They were observed to wear gloves. There was no gowns donned for enhanced barrier precautions. The resident's room was observed to have no enhanced barrier precaution signage in place or PPE supplies outside of the room. A care plan, dated 10/01/24, read in part, I have actual impairment to skin integrity of the neck related to infection of abscessed area to neck due to my cancer. A care plan, dated 10/04/24, read in part, I am on enhanced barrier precautions related to skin openings, abscesses due to my cancer .Apply appropriate PPE during all high-contact resident care activities .Notify all staff of enhanced barrier precautions. 2. Resident #69 had diagnoses which included malignant neoplasm of connective and soft tissue and local infection of the skin and subcutaneous tissue. A comprehensive assessment, dated 06/21/24, documented Resident #69's cognition was moderately impaired and dependent on staff for most activities of daily living. A physician's order, dated 06/19/24, read in part, Foley catheter care every shift and as needed. A physician's order, dated 09/24/24, read in part, Cleanse right anterior chest with wound cleanser, apply alginate rope with silver, apply collagen powder, cover with gauze island with boarder dressing daily x 30 days. On 10/02/24 at 9:45 a.m., Resident #69's room had no enhanced barrier precautions signage or PPE supply available outside of the room. On 10/02/24 at 9:49 a.m, ADON #1 provided wound care to the right side of Resident #69's chest. The ADON wore gloves to perform wound care, but no other PPE was donned related to enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/24 at 2:09 p.m., CNA #3 donned a gown and gloves to empty Resident #69's Foley catheter bag. The CNA reported they did not like them to wear gowns to empty the Foley catheter bags, but they had started using them because it is messy. The resident's room was observed to have an enhanced barrier precautions signage on the door at this time. A care plan, dated 10/04/24, read in part, I am on enhanced barrier precautions related to nonhealing surgical incision and indwelling catheter. 3. Resident #49 had diagnoses which included diabetes mellitus. A comprehensive assessment, dated 09/01/24, documented Resident #49's cognition was moderately impaired and required substantial/maximal assistance with activities of daily living. A physician's order, dated 09/30/24, read in part, Initiate contact isolation precautions for MRSA in the would of the toe .Gentamicin sulfate external ointment 0.1% apply to left great toe topically one time a day for wound infection x 10 days. A care plan, dated 10/01/24, read in part, I have a diabetic ulcer of the left great toe related to diabetes .I do have MRSA to my toe, new orders and antibiotics obtained following results of wound culture .Contact isolation initiated. On 10/02/24 at 12:34 p.m., Resident #49 was observed setting up in the recliner in their room with their feet elevated. The resident's wound to the left great toe was observed with no dressing in place. The resident reported the dressing was removed before their shower. The wound care nurse provided wound care to left great toe wearing gloves, no other PPE was used. The wound care nurse reported the resident's wound culture came back as a staph infection and they were treating with gentamycin ointment (antibiotic) for 10 days. The wound care nurse disposed of used wound care supplies in a clear plastic bag, then removed from the clear plastic bag from the room and placed the bag in the side trash can of the treatment cart. On 10/02/24 at 2:34 p.m., ADON#2 reported not being aware of any resident having MRSA in a wound or on contact precautions. They reported signage for isolation, biohazard bags in the room, and PPE outside side the residents door should be in place for a resident on transmission based/contact . The ADON reported the wound care nurse/infection preventionist and charge nurse were responsible to ensure staff were aware of residents on isolation and putting out the PPE supplies and isolation signage. The ADON reported enhanced barrier precaution signage should not be used if a resident was on isolation precautions. They reported contact precautions for Resident #49 should have been put into place when the order was received. On 10/02/24 at 3:00 p.m., ADON #2 reported Resident #49 should have had contact precautions in place, but staff had failed to do so. They reported residents with a Foley catheter and open wounds should have enhanced barrier precautions used by staff for catheter care and wound care. The ADON was not aware the reason staff were not following enhanced barrier precautions or the reason signage was not in place.