STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375433	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vian Nursing & Rehab, LLC	305 North Thornton Vian, OK 74962

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 - Actual harm 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)

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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(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 - Actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure a resident was not burned by a hot drink for 1 (#1) of 4 sampled residents reviewed for accident hazards related to hot drinks.The administrator identified 53 residents resided at the facility.Findings:A facility policy titled Safety of Hot Liquids, dated October 2014, read in part, Residents will be evaluated for safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions will be implemented to maximize choices of beverages while minimizing the potential for injury.The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions.A significant change assessment, dated 05/20/25, showed in Section C Res #1 had a BIMS (brief interview for mental status) score of 06 (a score of 06 indicated the resident's cognition was severely impaired). Section I of the assessment showed Res #1 had the diagnosis of acute and chronic respiratory failure with hypoxia.A progress note, dated 07/15/25 at 4:22 p.m., showed LPN #1 had observed Res #1 laying in bed and a coffee mug had been provided to the resident by a staff member. The note showed the nurse had assessed the resident and found coffee had been spilled on the resident's legs, buttock, and thighs. The note showed LPN #1 observed a 2 inch by 2.5 inch open area located on the resident's left lower hip, a 2 inch by 0.5 inch blister on the resident's left buttock, and a 1.5 inch by 1 inch blister located on the resident's right buttock. The note showed the resident had a blood oxygen saturation rate (a measurement of oxygen circulating in the blood steam) of 88% and LPN #1 observed the resident quickly fell asleep during the assessment. The note showed LPN #1 further documented in the note the resident had been transferred to a community acute care hospital at approximately 2:00 p.m.A hospital assessment document, dated 07/15/25, showed Res #1 had burns to their groin and buttock and respiratory failure. The document showed the resident had second degree burns that were described as partial thickness loss and blisters on the resident's sacrum, left buttock, left posterior thigh, suprapubic, and groin areas. On 07/18/25 at 12:00 p.m. the administrator and this surveyor reviewed video footage from the camera that had a view of Res #1's hallway. According to the time stamp on the video, PT #1 entered Res #1's room with a coffee mug on 07/15/25 at 11:34 a.m. CNA #1 entered Res #1's room at 12:27 p.m. with a food tray. At 12:28 p.m., CNA #1 was observed leaving Res #1's room without the food tray. At 12:29 p.m., CNA #1 was observed entering Res #1's room with a towel in their hand. At 12:32 p.m., CNA #1 was observed leaving Res #1's room with the towel. At 12:43 p.m. LPN #1 entered Res #1's room. The video did not show anyone remove a food tray or cups between the time CNA #1 entered with a food tray and the time LPN #1 entered the room at 12:43 p.m. On 07/17/25 at 3:20 p.m., LPN #1 was asked to describe the incident where Res #1 had been sent to a hospital for a burn. LPN #1 stated they had been Res #1's nurse on that day. They stated the resident's level of consciousness was down that day and they were lethargic (a state of physical and/or mental fatigue/tiredness) because Res #1 would not keep their CPAP (continuous positive airway pressure machine that supplies supplemental oxygen) mask on.On 07/18/25 at 9:24 a.m., CMA #1 was asked about Res #1's general condition on the day they had received the burn on 07/15/25. CMA #1 stated Res #1 was a little lethargic, had refused their medications that morning, and reported some shortness of breath. They stated the resident had a history of their oxygen levels getting low and at those times the resident would need assistance with eating. On 07/18/25 at 10:00 a.m. PT #1 was asked to describe the incident where Res #1 had been burned on 07/15/25. They stated on the day of the incident a staff member had told them the resident had not taken their medications that morning. They stated they went to see the resident to see if they could talk the resident into taking their medications. They stated when they arrived at the resident's room, they called the resident's name and the second time they called the resident's name the resident slightly opened their eyes. PT #1 stated Res #1 then asked them to get them some coffee. PT #1 stated they then went to the dining room and after finding the thermoses of coffee in the dining room were empty, they asked a kitchen staff member to fill a coffee mug for them. They stated the kitchen staff member did fill the mug from the coffee maker in the kitchen and they returned to Res #1's room with the filled coffee mug. They stated they put a straw into the top of the coffee mug and assisted Res #1 to drink the coffee. They stated they physically held the resident's head up from under their chin so the resident could take some sips of coffee through the straw. They stated the resident did take about three or four sips from the mug of coffee before they fell back asleep. PT #1 stated they then placed the coffee mug on the resident's bedside table that was positioned laterally next to