

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Pauls Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1413 South Chickasaw Street Pauls Valley, OK 73075	
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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were free from injuries resulting in a fracture for 1 (#3) of 4 sampled residents reviewed for accidents. The DON identified 36 residents resided in the facility. Findings: An undated diagnoses report for Resident #3's showed Resident #3 was admitted on [DATE] with a diagnosis of morbid obesity (severe) due to excessive calories. A comprehensive assessment for Resident #3, dated 04/12/25, showed the resident was dependent upon staff for all transfers. A care plan for Resident #3's, revised on 10/04/25, showed Resident #3 required a mechanical lift with two staff assistance for transfers. A Combined Initial and Final incident report, dated 06/04/25, read in part, 06/04/25 1330 [1:30 p.m.], staff was transferring [Resident #3] post shower, using hooyer lift. Lift sling broke with resident in the air causing [them] to fall to floor. [They] maintained A/O status, states [they] did not hit [their] head, but did c/o 10/10 pain to right leg. Right leg was rotated inward, warm to touch. Interview with staff. There were 2 staff members assisting with Resident #3's care and present when sling broke. Inspection of sling showed loop that hooks onto mechanical [lift] tore. Disposed of this sling. A Follow up Information incident report, received on 06/09/25, read in part, Charge nurse spoke to [name withheld]. Resident #3 had surgery on 06/05/25 for Femur fracture. Review of investigation records showed no documentation for monitoring of slings for good repair. On 12/17/25 at 3:07 p.m., CMA #1 stated when they were transferring Resident #3, the bottom loops left side ripped apart and they slid out, they went to the floor and on the legs of the lift. On 12/17/25 at 3:11 p.m., CMA #2 stated two staff when using the lift always and they triple check the slings which we did. On 12/17/25 at 3:52 p.m., the administrator stated there was no documentation slings being monitored for frays or holes.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 375463
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