STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375466	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Drumright Nursing Home	701 N Bristow Ave Drumright, OK 74030

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. Based on record review and interview, the facility failed to:a. prevent a fall during transportation for 1 (#2); andb. ensure interventions were initiated after a fall for 1 (#9) of 3 sampled residents reviewed for accidents.The DON identified 48 residents resided in the facility. Findings:An INCIDENT POLICY AND PROCEDURE policy, revised 03/31/23, read in part, The charge nurse will complete an incident report including all information known about the incident as well as immediate corrective measures implemented.1. Resident #2's admission resident assessment, dated 08/14/25, showed the resident had diagnoses which included severe protein-calorie malnutrition and adult failure to thrive. The assessment showed the resident's cognition was intact with a BIMS of 14. The assessment showed the resident was dependent on staff assistance for on activities of daily living and transfers. A hospital After Visit Summary, dated 09/11/25, showed Resident #2 had diagnoses which included fall, injury of head, and laceration of right lower extremity.A combined Initial and Final State Reportable Incident form, dated 09/12/25, showed certain injuries. The incident form showed Resident #2 slid out of their wheelchair and had a laceration to their right lower leg during transportation of the resident to their doctor's appointment. The incident report showed the resident was taken to the nearest hospital and had seven sutures to their right lower extremity. The incident report showed during investigation, the transport van did not have working seatbelt for the transportation of residents in a wheelchair.On 09/15/25 at 1:19 p.m., Resident #2 stated they fell in the transport van on 09/11/25 on their way to an appointment because they were not buckled in correctly. They stated they were taken to the emergency room and received six to seven stitches on their right shin. Resident #2 stated the transport driver was instructed to take them to the nearest hospital instead of calling 911.On 09/17/25 at 12:35 p.m., transporter #1 stated they started transporting residents the week of 09/08/25.On 09/17/25 at 12:36 p.m., transporter #1 stated Resident #2 was in a wheelchair and there were four buckles to secure the wheelchair to the van. They stated they were not aware the resident needed to be secured.On 09/17/25 at 12:38 p.m., transporter #1 stated they were not educated on what was needed for transportation of residents.On 09/17/25 at 12:39 p.m., transporter #1 stated they had slowed down due to construction on the road and heard Resident #2 yell. They stated they looked back and saw the resident's leg had hit the ledge in front of them and was bleeding. They stated they were going at a speed of about 10 miles per hour. Transported #1 stated they pulled over into a safe area, unhooked the resident's wheelchair, and laid them on the floor of the van. Transporter #1 stated they called the IP and was instructed to take the resident to the nearest hospital which was about three to four minutes away.On 09/17/25 at 2:22 p.m., the administrator stated maintenance personnel, transporter #1, and themselves were responsible for transporting residents. They stated transporter #1 started transporting residents in September 2025.On 09/17/25 at 2:27 p.m., administrator stated the facility did not have any specific routine safety checks for the transport van prior to the incident onOn 09/17/25 at 2:36 p.m., the administrator stated the van did not have a wheelchair seatbelt because they could not find the other strap. They stated transporter #1 did not notify the administrator of the missing wheelchair seatbelt and proceeded to transport the resident to their appointment. The administrator stated transporter #1 failed to secure Resident #2 (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	during transport.2. A fall incident report, dated 08/09/25 at 9:30 a.m., showed Resident #9 was found lying on their back at the corner of the foot of the bed. The incident report showed the resident was unable to give reason for the fall and there were no injuries.There was no documentation any interventions were implemented to prevent future falls related to the fall incident on 08/09/25.A fall incident report, dated 08/15/25 at 7:15 a.m., showed Resident #9 was trying to get out of their wheelchair unassisted and slid to their buttock with the feet rest of the wheelchair under the resident. The incident report showed the resident sustained a skin tear above their right elbow and was not wearing nonskid socks.There was no documentation any interventions were implemented to prevent future falls or injury related to the fall incident on 08/15/25.A fall incident report, dated 08/26/25 at 10:00 a.m., showed Resident #9 was found sitting on the floor. Resident #9 stated they scooted themselves down onto the floor on the edge of their bed. The incident report showed the resident stated they hit their head. Neurological checks were initiated, and the resident was put on one on one until they became sleepy.There was no documentation any interventions were implemented to prevent future falls or injury related to the fall incident on 08/26/25.Resident #9's significant change in status resident assessment, dated 09/02/25, showed the resident's cognition was severely impaired with a BIMS of 03.A care plan, revised 09/11/25, showed Resident #9 had diagnoses of dementia in other diseases classified elsewhere, moderate, without disturbance, psychotic disturbance, mood disturbance, and anxiety, history of falling, and unsteadiness on feet. The care plan showed Resident #9 was a high risk for falls related to confusion, gait and balance problems, and unaware of safety needs.On 09/18/25 at 1:46 p.m., LPN #1 stated nurses initiated fall interventions based on the root cause of the fall.On 09/18/25 at 2:46 p.m., the ADON stated there were no fall interventions for the above dates. They stated interventions could include the use of a fall mat, remove footrest, and keep the bed low.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure PRN psychotropic medications were limited to 14 days for 2 (#9 and #28) of 5 sampled residents reviewed for unnecessary medication.The DON identified 48 residents resided in the facility. Findings: An undated facility policy titled Other drugs needing special handling and attention, read in part, Psychotropics drugs effective 11.28.17 PRN orders for psychotropic drugs are limited to 14 days, unless the physician believes that it is appropriate for the PRN to be extended beyond 14 days. The physician will document their rationale in the resident's medical record and indicate the duration of the PRN order. 1.Resident #9's physician's order, dated 07/25/25, showed lorazepam (antianxiety medication) 0.5 mg tablet. Give 0.5 mg by mouth every six hours as needed for anxiety related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #9's order for lorazepam had no stop date. An August 2025 MAR showed lorazepam was administered 14 times past the 14 days. The MAR showed the medication was administered on 08/09/25, 08/11/25, 08/12/25, 08/13/25, 08/14/25, 08/15/25, 08/16/25, 08/17/25, 08/19/25, 08/21/25, 08/23/25, 08/27/25, and 08/28/25. Resident #9's significant change in status resident assessment, dated 09/02/25, showed the resident's cognition was severely impaired with a BIMS of 03. A care plan, revised 09/11/25, showed Resident #9 had diagnoses of dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The care plan showed the resident received antianxiety medication. A September 2025 MAR showed lorazepam was administered four times. The MAR showed the medication was administered on 09/02/25, 09/03/25, and 09/04/25. On 09/19/25 at 9:39 a.m., the DON stated PRN use of psychotropics was limited to 14 days unless the physician documented a rationale in the resident's medical record. On 09/19/25 at 9:40 a.m., the DON stated Resident #9's lorazepam order had no stop date. On 09/19/25 at 9:46 a.m., the DON stated the pharmacist consult, dated 08/14/25, showed the physician needed to evaluate the PRN use of lorazepam for Resident #9. They stated the physician's response, dated 08/18/25, showed no changes and no rationale was provided for the continuation of PRN lorazepam. On 09/19/25 at 9:50 a.m., the DON stated Resident #9 received lorazepam three times in July 2025, 18 times in August 2025, and four times in September 2025. 2. Resident #28's admission assessment, dated 07/07/25, showed the resident's cognition was moderately impaired with a BIMS of 9. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28's physician's order, dated 08/27/25, for Ativan/lorazepam 2mg/1ml apply to neck/wrist topically every six hours as needed for anxiety/refusal to take PO meds for 60 days. The stop date for the Ativan was for 10/26/25. Resident #28's physician's order, dated 09/08/25, for ABH (Ativan-antianxiety medication, Benadryl-antihistamine medication, Haldol-antipsychotic medication combination used for severe agitation) gel apply to neck/wrist topically every six hours as needed for agitation/refusal PO meds for 60 days. The stop date for the ABH was for 11/07/25. A care plan, revised 09/09/25, showed Resident #28 had diagnoses of disruptive mood dysregulation disorder, anxiety disorder, mild cognitive impairment, disorientation, manic episode, behavioral disturbance related to Alzheimer's and dementia. The care plan showed the resident received psychotropic medications. Resident #28's August 2025 MAR showed lorazepam was administered six times. The Ativan had been administered after the 14 days from when it was ordered on 08/27/25. The stop date did not meet regulatory standard of 14 days then reevaluate. Resident #28's September 2025 MAR showed ABH gel was administered one time and the lorazepam was administered seven times. The stop date did not meet regulatory standard of 14 days then reevaluate. On 09/19/25 at 2:38 p.m., LPN #2 stated the ABH gel was ordered on 09/08/25 with an end date of 11/07/25. They stated it was to be for no more than 14 days. LPN #2 stated the order was for 60 days. LPN #2 stated they were required to have an assessment after 14 days. LPN #2 stated Resident #28 received the ABH gel on 09/09/25 which was within the 14 days, but it did not meet the 14 day requirement. On 09/19/25 at 2:46 p.m., LPN #2 stated the Ativan PRN was started on 08/27/25 with a stop date of 10/26/25. They stated it was ordered for 60 days. They stated it had exceeded 14 days. They stated PRN psych medications needed to be assessed after 14 days. LPN #2 stated Resident #28 received Ativan five days in August 2025. They stated on the 27th, 28th, 29th, 30th, and 31st. LPN #2 stated Resident #28 received Ativan five days in September 2025. They stated on the 1st, 2nd, 3rd, 4th, 5th, and 8th. On 09/19/25 at 2:52 p.m., LPN #2 was asked if there was a rational for both PRN medications to exceed the 14 days. They stated if the person putting in the order did not put to reassess, then it would default to the 60 days.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's discharge assessment was transmitted for 1 (#24) of 12 sampled residents whose assessments were reviewed.The DON identified 48 residents resided in the facility. Findings:Resident #24's discharge assessment return not anticipated, dated 05/31/25, showed the resident had a planned discharge on [DATE].There was no documentation the discharge resident assessment was transmitted.On 09/22/25 at 10:03 a.m., the ADON stated the registered nurse was responsible for transmitting the completed resident assessments.On 09/22/25 at 10:06 a.m., the IP stated they tried to transmit resident assessments within five days of completion.On 09/22/25 at 10:09 a.m., the IP stated Resident #24's discharge assessment dated [DATE] was not transmitted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure a nebulizer mask and tubing was stored in a manner to prevent cross contamination for 1 (#58) of 1 sampled resident reviewed for respiratory care.The DON identified 48 residents resided in the facility. Findings: On 09/15/25 at 12:42 p.m., a nebulizer mask was observed laying on Resident #58's nightstand.On 09/22/25 at 10:46 a.m., a nebulizer mask was observed laying on Resident #58's nightstand. The part of the tubing that connected to the machine was laying on the floor by the resident's bed.An undated facility policy titled POLICY AND PROCEDURE REGARDING CLEANING AND MAINTENANCE OF NEBULIZERS, OXYGEN SUPPLIES AND METERED DOSE INHALERS, read in part, when the equipment is not in use, it may be stored in a plastic container or covering.Resident #58's physician's order, dated 09/08/25, showed ipratropium-albuterol inhalation solution (a breathing treatment) 3mg/3ml, inhale one vial orally four times a day for wheezing.Resident #58's admission resident assessment, dated 09/12/25, showed the resident's cognition was severely impaired with a BIMS of 06.A care plan, dated 09/15/25, showed Resident #58 had diagnosis of unspecified chronic obstructive pulmonary disease and received breathing treatments.On 09/15/25 at 12:41 p.m., Resident #58 stated they received nebulizer treatments daily.On 09/22/25 at 10:48 a.m., LPN #1 stated after nebulizer treatment, they would clean the nebulizer mask, set it on a paper towel, and leave it on the sink to air dry in the resident's room. They stated they would leave the mask at the sink until the next treatment.On 09/22/25 at 10:52 a.m., LPN #1 stated Resident #58's nebulizer mask and tubing was not stored appropriately. They stated the tubing was on the floor.On 09/22/25 at 10:55 a.m., the DON stated the nebulizer mask should be cleaned with soap and water, air dried, and stored in a plastic container or covering when not in use. They stated the container or covering should be labeled with the resident's name.