STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375471	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linwood Village Nursing & Retirement Apts	530 South Linwood Avenue Cushing, OK 74023

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to ensure a resident was free from abuse for 1 (#162) of 2 sampled residents reviewed for abuse. The administrator identified 55 residents resided in the facility. Findings: A policy titled Abuse,Neglect and Exploitation, dated 01/01/25, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect.The facility will make efforts to ensure all residents are protection from physical and psychosocial harm. An initial OSDH Incident Report Form, for the incident date 02/07/25 Part B, read in part, [Resident #162] told the shower aids, late Friday afternoon, that in the night [they] had asked the aide for ice water and [they] threw a cup of water in [their] face. No injuries were noted. [Resident #162] has been a resident since 12/27/24 on skilled services. [Resident #162] had a slip and fall accident in November 2024 which has left [them] with partial paralysis. [Resident #162] has lucid days and confused days. Part C , read in part, The CNA was put on suspension pending investigation. A final OSDH Incident Report Form, for the 02/07/25 incident, showed, Part C read in part, The CNA was put on suspension pending investigation.An investigation substantiated the claim. Resident #162's quarterly MDS assessment, dated 04/05/25, showed a BIMS of 6 meaning severe cognitive impairment, dependent with ADLs, and diagnoses of traumatic spinal cord dysfunction, quadriplegia, and anxiety. On 05/22/25 at 2:12 p.m., CNA #1 stated abuse was if residents were not taken care of, or if they saw any bruising,.CNA #1 stated they would get the nurse or administrator immediately. CNA #1 stated Resident #162 was total care and had to be fed. On 05/22/25 at 2:18 p.m., the DON, with the regional administrator present, stated the policy for abuse was if someone was concerned to report to a superior or tell your administrator. On 05/22/25 at 2:20 p.m., the DON stated the resident and the 2 CNA's were the only ones in the room with the resident at the time of the incident. The DON stated Resident #162 was cognitively intact at times and was adamant that it happened.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to ensure a thorough investigation was completed for an allegation of abuse for 1(#162) of 2 sampled residents reviewed for abuse. The administrator identified 55 residents resided in the facility. Findings: A policy titled Abuse,Neglect and Exploitation, dated 01/01/25, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect.The facility will make efforts to ensure all residents are protection from physical and psychosocial harm. An initial OSDH Incident Report Form, for the incident on 02/07/25 Part B, read in part, Resident #162] told the shower aids, late Friday afternoon, that in the night [Resident #162] had asked the aide for ice water and [Resident #162] threw a cup of water in [CNA #1] face. No injuries were noted. [Resident #162] has been a resident since 12/27/24 on skilled services. [Resident #162] had a slip and fall accident in November 2024 which has left [Resident #162] with partial paralysis. [Resident #162] has lucid days and confused days. Part C read in part, The CNA was put on suspension pending investigation. A final OSDH Incident Report Form, for the 02/07/25 incident, showed, Part C read in part, The CNA was put on suspension pending investigation. An investigation substantiated the claim. Resident #162's quarterly MDS assessment, dated 04/05/25, showed a BIMS of 6 meaning severe cognitive impairment, dependent with ADLs, and diagnoses of traumatic spinal cord dysfunction, quadriplegia, and anxiety. On 05/22/25 at 2:12 p.m., CNA #1 stated abuse was if residents were not taken care of or if they saw any bruising. CNA #1 stated they would get the nurse or administrator immediately. CNA #1 stated Resident #162 was total care and had to be fed. On 05/22/25 at 2:18 p.m., the DON, with the regional administrator present, stated for an abuse investigation they do a state reportable On 05/22/25 at 2:20 p.m., the DON stated the resident and the 2 CNA's were the only ones in the room with the resident at the time of the incident. The DON stated Resident #162 was cognitively intact at times and was adamant that it happened. On 05/22/25 at 2:38 p.m., the DON stated they did not do resident interviews other than Resident #162. They stated there was no other staff to interview about the incident as there were only the two CNA's in the room at the time of the incident, other than when Resident #162 told the CNA's giving them the shower. The DON stated CNA #2 had other complaints about them from residents prior. The DON stated they were not sure if the reporting to the registry was done. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Oklahoma State Department of Health Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property, notification fax transmission was not located. On 05/23/25 at 9:35 a.m. the regional administrator stated they did not send to the nurse aide registry, they just sent to OSDH. They stated they had just found out they needed to send to both. On 05/23/25 at 9:40 a.m., the regional administrator stated the BOM had pulled the file and CNA #2 had not completed the actual training in the computer software system used. They stated staff was given fourteen days to complete the training's and CNA #2 never turned it in. The facility did not perform any additional resident interviews to ensure other residents were not affected by the allegation. The facility did not interview any staff regarding the CNA's behavior towards resident to ensure the CNA had not affected them. The facility was unable to provide proof of notification of CNA #2's allegations to the state agency for CNA reporting.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure dented cans, and opened bottles were removed from circulation in the dry storage. The administrator identified 55 residents resided in the facility and ate from the kitchen. Findings: On 05/20/25 at 9:53 a.m., two 2.6 pound cans of hot dog chili sauce, and a can of tuna were observed to have dents along the seals. A plastic bottle of red food dye had torn foil covering the opening, leaving the bottle open to air. The date of receival written on the cans was 02/25. A policy Food Receiving and Storage, revised November 2022, read in part, Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. On 05/20/25 at 10:03 a.m., the DM stated the staff had dropped the chili cans, so the dietician told them they could serve the chili since they knew when the damage occurred. The DM stated he did not notice the can of tuna was bent or that the foil did not secure the bottle of food coloring. On 05/23/25 at 11:20 a.m., the dietician stated if the cans were damaged, they should have been thrown out if they were not served that day.

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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 record review and interview, the facility failed to ensure a water management plan to prevent waterborne pathogens had been implemented. The administrator reported 55 residents resided at the facility. Findings: A facility policy titled Water Management Program, implemented 09/08/23, read in part, It is the policy of this facility to establish water management plans for reducing the risk of Legionellosis and other opportunistic pathogens in the facility's water systems based on nationally accepted standards .Documentation of all the activities related to the water management program shall be maintained in the water management program binder for a minimum of three years. On 05/23/25 at 10:31 a.m., the DON, regional administrator, and maintenance director were unable to provide documentation of any measures to prevent growth of Legionella. The maintenance director stated they did not really know about Legionella prevention.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to ensure abuse training on hire was conducted for 1 (CNA #2) of 3 staff members files who's employee files reviewed. The administrator identified 55 residents resided in the facility. Findings: The employee file for CNA #2 showed a hire date of 01/28/25. There was no abuse training on hire located in the employee file. On 05/23/25 at 9:40 a.m., the regional administrator stated the BOM had pulled the file and CNA #2 had not completed the actual training in the computer software system used. They stated staff was given fourteen days to complete the training's and CNA #2 never turned it in.