STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Post Acute & Rehab	1700 Northwest Fort Sill Blvd Lawton, OK 73507

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician and family were notified when a resident had a significant change of condition for 1 (#96) of 1 sampled resident reviewed for a change of condition which resulted in death. Resident #96 was on the toilet and bleeding. ACMA #2 stated they contacted LPN #1 about the residents' condition, and they had left the blood in the toilet for LPN #1 to observe. LPN #1 came to observe the resident; however, LPN #1 told them to continue to monitor the resident since they had refused to go to the ER. The physician or family was not notified of the serious change in condition of Resident #96.The administrator identified 80 residents resided in the facility.On [DATE], an IJ situation was determined to exist related to the facility's failure to notify the physician and family of a change in condition for Resident #96 who was reported to have active bleeding which resulted in death. On [DATE] at 5:24 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On [DATE] at 5:37 p.m., the administrator and DON were verbally notified of the IJ in existence and provided the IJ template via email at 5:57 p.m.On [DATE] at 2:23 p.m., an acceptable POR was approved by the Oklahoma State Department of Health. The plan of removal read in part, Immediate Jeopardy Removal Plan - F580 (Notification of Changes) Immediate Resident Protection: The facility DON and nursing leadership conducted an immediate, house-wide assessment of all current residents. We verified that all required Physician and Family/Responsible Party notifications were properly completed and documented for these residents as of [DATE]. Immediate Corrective Action: The facility has implemented a strict, notification protocol. Any licensed nurse who identifies a significant change in a resident's condition-specifically including the acute onset of bleeding or EMS transfer - must notify the Attending Physician and the Family/Responsible Party without delay. Mandatory Staff Training: A mandatory in-service has been initiated for all licensed nursing staff regarding F580 (Notification of Changes) by the DON or Designee. This POR will be completed by [DATE]. Staff trained by [DATE] any unavailable staff will receive training before returning to work.The IJ was lifted, effective [DATE] at 2:32 p.m., when all components of the plan of removal had been verified as completed. A review of the notification protocol was conducted. In-service training regarding notification of changes was reviewed, and staff were interviewed to ensure the in-service training had been completed. The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy.Findings:An Acute Condition Changes policy, dated [DATE], read in part, The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response. As needed, the physician will discuss with the staff and resident or family the pros and cons of diagnosing and managing the situation in the facility or the need for hospitalization.A physician's order for Resident #96, dated [DATE], showed:a. Eliquis (anticoagulant) 2.5 mg twice a day andb. anticoagulant medication - Monitor for discolored urine, black tarry stools, sudden severe headache, nausea/vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath and nose bleeds each shift.An admission assessment for (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #96, dated [DATE], showed the resident's cognition was moderately impaired with a BIMS score of 11. The assessment showed the resident required supervision with ambulation and transfers. The assessment showed the resident required partial to moderate assistance with toileting hygiene.A care plan for Resident #96, dated [DATE], showed the resident was on anticoagulant therapy related to atrial fibrillation. The care plan showed to monitor/document/report PRN adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, and loss of appetite.An admission contract signed on [DATE], showed family member #1 was the emergency contact, and the contact phone number was listed.An EMS report for Resident #96, dated [DATE], showed EMS was dispatched by the facility at 3:12 a.m. and arrived at the facility at 3:20 a.m. The report showed facility staff reported Resident #96 had experienced some blood in the stool starting three hours prior. The report showed the resident was recovering from abdominal aortic aneurysm surgery. The report showed the resident's room had signs of a significant hemorrhagic event, with towels in the corner of the room saturated with blood, and blood on the floor in various spots. The report showed the resident was on the toilet, unconscious, breathing, had blood on their socks, blood down their legs, and blood in/on the toilet. The report showed the resident left the building at 3:35 a.m. with EMS for transport to the hospital, and expired in the ambulance at 3:40 a.m. while still in the facility parking lot.A First Call Sheet police report for Resident #96, dated [DATE], showed no next of kin.Progress notes for Resident #96 did not show contact was made with the physician or family on [DATE].A progress note for Resident #96, dated [DATE], showed LPN #1 was notified at 1:32 a.m., Resident #96 had increased anxiety, was screaming they could not breathe, was on the toilet, and most of the contents were blood. The note showed the resident was educated about the need to go to the emergency department and the refusal. The note showed the resident became confused, EMS was contacted and arrived at 3:15 a.m., and left the facility with the resident at 3:35 a.m.On [DATE] at 2:45 p.m., family member #1 stated they were not contacted by the facility about the change in condition for Resident #96. Family member #1 stated they were not notified of the resident's passing until 8:46 a.m. on [DATE]. Family member #1 stated they were the resident's POA and emergency contact. Family member #1 stated the emergency contact information was provided to the facility in the admission paperwork.On [DATE] at 9:53 a.m., CNA #1 stated around 3:00 a.m. on [DATE], they were across the hall from Resident #96's room. CNA #1 stated Resident #96 was screaming they could not breathe. CNA #1 stated they alerted ACMA #2 of the resident's condition. CNA #1 stated the resident was sitting on the toilet, and the toilet was full of blood. CNA #1 reported the resident refused to go to the hospital because they were scaredOn [DATE] at 10:29 a.m., LPN #1 stated they had failed to contact Resident #96's physician and family with the change in condition on [DATE]. LPN #1 reported they were busy with other tasks, and the resident was being monitored by ACMA #2 in charge of the resident's hall. On [DATE] at 11:22 a.m., ACMA #2 stated on [DATE] at 1:15 a.m., Resident #96 was on the toilet again and bleeding, their vitals were ok, and they refused to go to the ER. ACMA #2 stated they contacted LPN #1 about the residents' condition and refusal to go to the ER. ACMA #2 stated the resident was back in bed when LPN #1 came to the room at 1:32 a.m., to check on the resident. ACMA #2 stated they had left the blood in the toilet for LPN #1 to observe. ACMA #2 stated LPN #1 told them to continue to monitor the resident since they had refused to go to the ER.On [DATE] at 11:24 a.m., ACMA #2 stated Resident #96 was on the toilet again at around 2:00 a.m. on [DATE], so they texted LPN #1 and were instructed to contact the family to see if they could get the resident to go to the ER. ACMA #2 stated no family contact was listed in the medical record. ACMA #2 stated at 2:50 a.m., the resident was again on the toilet, was passing blood, had pain, declined pain medications, and declined to go to the hospital. ACMA #2 stated the resident became pale and was shivering, so they called 911. ACMA #2 stated when EMS arrived the resident was back on the toilet and had passed out. ACMA #2 stated the charge nurse only went to the resident's room one time to assess them at 1:32 a.m.On [DATE] at 1:03 p.m., ACMA #2 stated they did not call the (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician about Resident #96's change of condition and were not aware if the charge nurse called the physician. ACMA #2 stated they were not instructed to call 911. ACMA #2 stated they did so because the resident was pale and shivering.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was assessed and monitored by a licensed nurse for a significant change of condition and profuse bleeding for 1 (#96) of 1 sampled resident reviewed for neglect. LPN #1 was notified on [DATE] at 1:15 a.m. of Resident #96 with bleeding from an unknown source and failed to complete an assessment. EMS was notified at 3:12 a.m., left the building with Resident #96 at 3:35 a.m. and the resident ultimately expired in the ambulance at 3:40 a.m.The administrator identified 80 residents resided in the facility.Findings:A policy titled Acute Condition Changes - Clinical Protocol, dated 03/2018, read in part, The physician will help identify individuals with a significant risk for having acute changes of condition during their stay. In addition, the nurse shall assess and document/report the following baseline information:a. Vital signs,b. Neurological status,c. Current level of pain and any recent changes in pain level,d. Level of consciousness,e. Cognitive and emotional status,f. Resident's age and sex,g. Onset, duration, severity,h. Recent labs,i. History of psychiatric disturbances, mental illness, depression, etc.,j. All active diagnoses, andk. All current medications.The policy read in part, Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less).A physician's order for Resident #96, dated [DATE], showed CBC and CMP weekly while on skilled services.An admission assessment for Resident #96, dated [DATE], showed the resident's cognition was moderately impaired with a BIMS score of 11. The assessment showed the resident required supervision with ambulation and transfers. The assessment showed the resident required partial to moderate assistance with toileting hygiene.A laboratory report for Resident #96, dated [DATE] at 1:05 p.m., showed a low hemoglobin (blood count) level of 6.3. The reference range showed 13.7 - 17.5 g/dl (grams per deciliter.) The comments showed the lab attempted to call the facility at 3:35 p.m., with no answer, and called again, unable to reach a nurse. The laboratory report showed it was released on [DATE] at 4:10 p.m.A care plan for Resident #96, initiated [DATE], showed the resident had an altered cardiovascular status related to status post abdominal aortic aneurysm repair. The care plan showed to monitor/document/report PRN any signs and symptoms of coronary artery disease.A care plan for Resident #96, initiated [DATE], showed the resident was on anticoagulant therapy r/t atrial fibrillation. The care plan showed to monitor/document/report PRN adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, and loss of appetite.An EMS report for Resident #96, dated [DATE], showed they were dispatched by the facility at 3:12 a.m. and arrived at the facility at 3:20 a.m. The report showed facility staff reported Resident #96 had experienced some blood in the stool starting three hours prior. The report showed the resident was recovering from abdominal aortic aneurysm surgery. The report showed the resident's room had signs of a significant hemorrhagic event, with towels in the corner of the room saturated with blood, and blood on the floor in various spots. The report showed the resident was on the toilet, unconscious, breathing, had blood on their socks, blood down their legs, and blood in/on the toilet. The report showed the resident left the building at 3:35 a.m. with EMS for transport to the hospital, and expired in the ambulance at 3:40 a.m. while still in the facility parking lot.Progress notes for Resident #96 did not contain documentation of a significant change in condition. The progress notes did not contain documentation to show the resident was assessed, or an intervention was conducted for the resident's shortness of breath, screaming, blood in the toilet, and refusal to be transported to the hospital on [DATE].A progress note for Resident #96, dated [DATE], showed LPN #1 was notified at 1:32 a.m. that Resident #96 had (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	increased anxiety, was screaming they could not breathe, was on the toilet, and most of the contents were blood. The note showed the resident was educated about the need to go to the emergency department and the refusal. The note showed the resident became confused, EMS was contacted and arrived at 3:15 a.m., and left the facility with the resident at 3:35 a.m.On [DATE] at 10:29 a.m., LPN #1 stated typically being the only licensed nurse in the building when they worked on the weekend, and they did not go to the South hall to get a full report since ACMA #2 was scheduled as charge to monitor residents. LPN #1 stated they would go to the South hall for falls, general questions, or concerns. LPN #1 stated they worked the North hall and did not go to the South hall unless needed.On [DATE] at 10:43 a.m., LPN #1 stated ACMA #2 reported Resident #96 was screaming, hurting, pooping, and there was blood. LPN #1 stated they were told the resident was there after an abdominal aortic aneurysm, and they were concerned about the resident bleeding out. LPN #1 stated that they had told ACMA #2 to send the resident to the hospital, but the resident continued to refuse. LPN #1 stated they received a text that showed a picture of the blood from ACMA #2 at 2:25 p.m. LPN #1 stated being traumatized by the amount of blood. LPN #1 stated they had not assessed and monitored the resident because they were behind on their work, and ACMA #2 was doing it and reporting to the nurse. LPN #1 stated they were behind on their work. On [DATE] at 11:10 a.m., LPN #1 stated it was not the standard operating procedure for the AMCA to assess, monitor, and send a resident out to the hospital. LPN #1 stated they had been late to work and were behind on their duties. On [DATE] at 3:53 p.m., the DON stated the procedure for critical lab results was that usually the lab called the facility and reported the lab results to the nurse, and the nurse reported immediately to the physician. The DON reviewed the lab report for Resident #96. The DON stated the physician was not notified of the results and should have been.On [DATE] at 1:31 p.m., the regional nurse consultant stated the incident regarding Resident #96 on [DATE] was considered neglect.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promptly assess, identify, and intervene when a resident experienced an acute new onset of profuse bleeding from an unknown source for 1 (#96) of 1 sampled resident reviewed for a change in condition when facility staff failed to notify the medical provider of a critical hemoglobin lab value of 6.3 with a normal reference range was 13.7 to 17.5, and identify the new onset of profuse bleeding from an unknown source on a resident with a recent repair of an abdominal aortic aneurysm resulting in an attempted transfer to the acute care hospital and subsequent death in the ambulance while in the facility parking lot.Specifically, the facility failed to: a. Identify, monitor, intervene, and provide continuing assessments for Resident #96 who was admitted with a recent history of an abdominal aortic aneurysm repair. b. Notify the medical provider of, or intervene, for Resident #96's critically abnormal lab value of a hemoglobin of 6.3, and c. Notify the medical provider of or intervene for the acute onset of profuse bleeding.These failures led to the attempted transfer of Resident #96 to an acute care hospital on [DATE] who ultimately expired in the ambulance on [DATE]. The administrator identified 80 residents resided in the facility.On [DATE] the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On [DATE] at 5:37 p.m., the administrator and DON were verbally notified of the IJ in existence and provided the IJ template via email at 5:57 p.m.On [DATE] at 2:23 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Immediate Jeopardy Removal Plan - F684 (Quality of Care)Immediate Resident Protection: On [DATE], the facility DON and nursing leadership conducted an immediate, house-wide assessment of all current residents to identify any active bleeding, recent injuries, or acute changes in condition. No residents were found to have unresolved bleeding or untreated conditions. Corrective Actions Implemented: The facility immediately implemented a strict Change of Condition Protocol, any licensed nurse made aware of any new onset bleeding or a significant change in condition is required to promptly assess the resident, obtain vital signs, apply first-aid/pressure if applicable, and notify the Physician and EMS as clinically appropriate, and then any family or emergency contact listed in the resident profile. The DON or designee will audit the incident reports and change in condition alerts daily to ensure interventions were documented and executed promptly.Staff Education: Mandatory education was initiated for all facility staff. Clinical staff were trained by the DON or Designee on the immediate assessment, monitoring, and physician notification requirements for profuse bleeding and changes in condition. Non-clinical staff were educated about identifying visual injuries or signs of resident distress and to report to nursing staff. This POR will be completed by [DATE]. Staff received education by [DATE] any unavailable staff will receive training before returning to work.The IJ was lifted, effective [DATE] at 2:32 p.m., when all components of the plan of removal had been verified as completed. Review of protocol for change of condition was conducted, clinical system changes were reviewed, education provided to staff was reviewed, clinical staff were interviewed regarding changes in protocol for change of condition, communication with facility staff and timely notification to physician of change in condition. Non-clinical staff were interviewed regarding what to do if a resident had a change in their condition. The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy.Findings: A policy titled, Acute Condition Changes - Clinical Protocol, dated 03/2018, read in part, The physician will help identify individuals with a significant risk for having acute changes of condition during their stay. In addition, the nurse shall assess and document/report the following baseline information:a. Vital signs;b. Neurological status;c. Current level of pain, and any recent changes in pain level;d. Level of consciousness;e. Cognitive and emotional status;f. Resident's age and sex;g. Onset, duration, severity;h. Recent labs;i. History of psychiatric disturbances, mental illness, depression, etc.;j. All active diagnoses; andk. All current medications.Direct care staff, including nursing assistants will be (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	trained in recognizing subtle but significant changes in the resident and how to communicate these changes to the Nurse. The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). A policy titled Lab and Diagnostic Test Results- Clinical Protocol, dated 11/2018, read in part, When test results are reported to the facility, a nurse will first review the results. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. An undated diagnosis list for Resident #96 showed encounter for surgical aftercare following surgery on the circulatory system and the presence of an aortocoronary bypass graft. Physician orders for Resident #96, dated [DATE], showed: a. CBC and CMP weekly while on skilled services; b. Aspirin (anti-inflammatory) 81 mg one time a day; c. Eliquis (blood thinner) 2.5 mg two times a day; d. Psyllium Oral Packet (constipation) one packet two times a day; e. Plavix (anti-platelet) 75 mg one time a day; and f. Imodium A-D (anti-diarrheal) 2 mg every 8 hours for loose stools for three days until finished. A nursing progress note for Resident #96, dated [DATE], at 3:51 p.m., showed a drug-to-drug interaction that Plavix may enhance the anticoagulant effect of direct oral anticoagulants. An undated order summary for Resident #96 showed the resident was admitted to the facility on [DATE] with diagnoses which include encounter for surgical aftercare following surgery on the circulatory system and presence of aortocoronary bypass graft. Resident #96 received a blood thinner twice a day and aspirin daily along with Psyllium Oral Packet (constipation) and Imodium A-D (anti-diarrheal). A nursing progress note for Resident #96, dated [DATE] at 10:50 a.m., showed the physician made rounds and was aware of the drug interactions. A nursing progress note for Resident #96, dated [DATE] at 10:58 a.m., showed Resident #96's family requested something for the daily diarrhea. A Laboratory Report, for Resident #96, dated received [DATE] at 1:05 p.m., showed hemoglobin (blood count) of 6.3. The reference range showed 13.7 - 17.5 g/dl (grams per deciliter) The lab report comments showed the facility was called at 3:35 p.m. with no answer and called again unable to reach nurse. The lab report showed the lab report was released on [DATE] at 4:10 p.m. The lab report showed staff signature dated for [DATE] on the lab report with the physician signature stamped at the bottom of the report. There was no date next to the physician stamped signature. A care plan for Resident #96 dated [DATE], showed the resident had altered cardiovascular status related to status post abdominal aortic aneurysm repair with bypass (procedure to route blood flow around blocked arteries). The care plan showed the resident would be free from complications of cardiac problems through the review date. The care plan showed to monitor/document/report PRN any signs and symptoms of coronary artery disease. A care plan for Resident #96 dated [DATE], showed the resident was on anticoagulant therapy related to atrial fibrillation. The care plan showed the resident would be free from discomfort or adverse reactions related to anticoagulant use through the review date. The care plan showed to monitor side effects and effectiveness every shift. The care plan showed to report abnormal lab results to the medical doctor. The care plan showed to monitor/document/report PRN reactions of anticoagulant therapy: black tarry stools, dark or bright red blood in stools, diarrhea, shortness of breath, sudden changes in mental status, and significant changes in vital signs. It showed to review medication list for adverse interactions and to avoid use of aspirin. The MAR for Resident #96, dated 03/2026, showed the resident received:a. Aspirin one time a day from [DATE] through [DATE],b. Eliquis two times a day (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	from [DATE] through [DATE],c. Psyllium one time a day on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], d. Imodium A-D once on [DATE], three times on [DATE], three times on [DATE], and two times on [DATE], ande. Plavix daily from [DATE] through [DATE]. A nursing progress note for Resident #96, dated [DATE] at 8:06 a.m., showed the staff stated Resident #96 was on the toilet when they became unconscious and was lowered to the floor around 1:15 a.m., the ambulance was called but the resident expired at 3:15 a.m., pronounced by [name withheld] ambulance. The nursing progress note for Resident #96 showed the resident had a bowel movement and started bleeding profusely and it did not stop. On [DATE] at 11:22 a.m., the ACMA #2 stated on [DATE] at 1:15 a.m., they notified LPN #1 Resident #96 exhibited signs of rectal bleeding. ACMA #2 stated LPN #1 did not assess Resident #96 when they were notified the resident showed signs of profuse bleeding, exhibited by bloody stool, shortness of breath, increased anxiety, or the refusal to go to the hospital. ACMA #2 stated LPN #1 instructed them to monitor and convince Resident #96 to go to the hospital. An EMS report, dated [DATE], showed they were dispatched by the facility at 3:12 a.m. and arrived at the facility at 3:20 a.m. The report showed facility staff reported Resident #96 had experienced some blood in the stool starting three hours prior. The report showed the resident was recovering from an abdominal aortic aneurysm surgery. The report showed the resident's room had signs of a significant hemorrhagic event, with towels in the corner of the room saturated with blood, and blood on the floor in various spots. The report showed the resident was on the toilet, unconscious, breathing, had blood on their socks, blood down their legs, and blood in/on the toilet. The report showed the resident left the building at 3:35 a.m. with EMS for transport to the hospital, and expired in the ambulance while still in the facility parking lot at 3:40 a.m. The nursing progress note for Resident #96 showed no significant change in condition, and showed no assessment, monitoring, or intervention was conducted for the resident's shortness of breath, screaming, blood in the toilet, and refusal to be transported to the hospital on [DATE]. A nursing progress note for Resident #96 from LPN #1, dated [DATE] at 6:38 a.m., read in part, Notified at 1:32 a.m., that the resident was having increased anxiety. [Resident #96] is screaming that [Resident #96] is on the toilet pooping. Oxygen saturation 98%. Most of the toilet contents were blood. Educated [Resident #96] that [they] needs [sic] to be sent out to the ED for evaluation and treatment. [Resident #96] refused. Educated [Residet #96] that we could not test or treat bleeds like [they] were experiencing. [Resident #96] became confused and EMS was called. They arrived at 0315 (3:15 a.m.) and left with the resident at 0335 (3:35 a.m.). On [DATE] at 2:45 p.m., family member of Resident #96 stated the resident had diarrhea since before admission and had tested negative for clostridium difficile and that the stool smell was horrendous and the color was black. The family member stated the staff was aware of the stool. On [DATE] at 3:43 p.m., CNA #6 stated they had assisted Resident #96 with toileting prior to the weekend of their death. They were unable to state which day. CNA #6 stated they observed the stool to be formed and mixed but not diarrhea, no odor. CNA #6 stated it looked like they may have taken iron as it was kind of dark black. The CNA stated they only saw it one time. On [DATE] at 10:36 a.m., LPN #1 stated, for a resident with a change in condition, typically, if a minor change, they would monitor for a little bit with vital signs, level of consciousness, and if something bigger like can't get them awake for meds they monitor for a little bit and if vital signs were abnormal then would get them out of there. On [DATE] at 10:43 a.m., LPN #1 stated ACMA #2 informed them at 1:32 a.m., of Resident #96 screaming they were hurting and they were pooping blood. They stated the resident refused pain medication. LPN #1 stated they were concerned Resident #96 was bleeding out. The LPN stated they told ACMA #2 to send the resident out to the hospital, but they kept refusing. LPN #1 stated they were told Resident #96 was there for an abdominal aortic aneurysm and they needed to go to the hospital. LPN #1 stated they were traumatized by the amount of blood. On [DATE] at 11:07 a.m., LPN #1 stated when ACMA #2 told them about the residents bloody stool and pain they just told ACMA #2 to convince Resident #96 to go to the hospital. LPN #1 stated they did not assess Resident #96 at 1:32 a.m. when the ACMA #2 informed them. They stated ACMA #2 did not tell (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Lawton Post Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Northwest Fort Sill Blvd Lawton, OK 73507	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	them about the bloody stool until 2:25 a.m. and told them to get the resident to the hospital. LPN #1 stated they were headed down to the resident when they were called to do something and was running behind because they were late to work. On [DATE] at 11:10 a.m., LPN #1 stated it was not the standard operating procedure for ACMA #2 to assess and send a resident out to the hospital. LPN #1 stated they did not visually see Resident #96 in distress. LPN #1 stated when they saw the resident they were on the toilet, alive, and did not see any blood anywhere. The LPN stated they saw pictures of the toilet after Resident #96 had gotten off of the toilet and saw fecal matter and blood-tinged water with a few drops on the towel and a piece of toilet paper. On [DATE] at 11:12 a.m., LPN #1 stated they were first notified Resident #96 presented as having a panic attack at 1:32 a.m. LPN #1 stated they determined there was an emergency when they saw pictures from ACMA #2 at 1:32 a.m. LPN #1 stated Resident #96 was having a panic attack at that time and did not have anything to give for it, they had refused medications, and they were pooping a lot and could not control the anxiety so they needed to go out. On [DATE] at 3:29 p.m., LPN #1 stated they received report Resident #96 had high anxiety and they had no medication for anxiety. LPN #1 stated they tried to convince Resident #96 to go to the emergency room. The LPN stated the resident was scared to go to the hospital. They stated the resident started showing signs of becoming hypovolemic (loss of fluid/blood) and needed to go to the hospital now or yesterday and refused to go and stated they Could not force them to go even if would save them. LPN #1 stated they called EMS. EMS then arrived about 10 minutes later and departed the building 20 minutes later with the resident. LPN #1 stated the police came shortly after the resident left. The LPN stated ACMA #2 had given Resident #96 DNR to the officer and was told they stopped cardiopulmonary resuscitation. On [DATE] at 3:31 p.m., LPN #1 stated they were typically the only nurse in the building on the weekend and did not go to the South side of the building to get a full report as they had ACMA #2 over there to monitor. LPN #1 stated they only went over there for falls and general questions or concerns. The LPN stated they usually stayed on the North side of the building and did not go over to the South side unless they were needed. On [DATE] at 2:42 p.m., CNA #6 stated they had assisted Resident #96 from the toilet earlier in the week maybe Monday, Tuesday, or Wednesday of last week and stated the resident had dark stool with clumps in it and was a mixture of solid and liquid, no red in it. CNA #6 stated the only education they had received about signs and symptoms of bleeding was a little from school. On [DATE] at 3:53 p.m., the DON stated the procedure for critical labs results was that usually the lab calls the facility and report the lab to the nurse and the nurse report immediately to the physician. The DON reviewed the lab report for Resident #96. The DON stated the signature on the report was ADON #1, signed on [DATE]. The DON stated the physician was not notified of the results and should have been.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to:a. ensure adequate supervision was provided and exit doors and perimeter fences were secure to prevent an elopement for 1 (#92) of 3 sampled residents reviewed for elopement risk.The administrator identified 80 residents resided in the facility. The DON identified six residents in the facility at risk for elopement.An elopement evaluation for Resident #92, dated 02/28/26, showed the resident was at risk for elopement and wandering. The evaluation showed the resident wandered around the facility into rooms. The evaluation showed Resident #92 was a new admit.A baseline care plan for Resident #92, dated 02/28/26, showed no interventions for wandering or a risk for elopement.Resident #92 was last seen in the facility on 03/07/26 at 11:10 a.m. The resident was not observed in their room at 11:20 a.m. The resident was found approximately three blocks away, Southwest of the facility, half block away from a busy four-lane road, and was returned to the facility by the facility staff at 11:30 a.m. The resident was assessed and observed to have abrasions to the top of their left hand and right knee that required first aid.On 03/13/26 at 8:30 a.m., the exit door in the dining room and the outside perimeter gate were observed to be unlocked. The door in the dining room exits to the outside smoking area. The smoking area had a perimeter fence with an unlocked gate that allowed access to a busy four-lane road.On 03/13/26 an IJ situation was determined to exist related to the facility's failure to provide adequate supervision for a resident who was known to be at risk for elopement.On 03/13/25 at 2:17 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On 03/13/26 at 2:20 p.m., the administrator was notified of the IJ situation and was provided the IJ template.On 03/13/26 at 4:54 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Facility responses and immediate action plan: To immediately abate the risk of serious harm and ensure the safety of the 6 identified at-risk residents, the facility has implemented the following immediate actions: Immediate Resident Safety: A 100% visual headcount of all facility residents was completed as of 3:30 p.m. 03/13/26. All residents are safely within the facility or on known outings with family. Immediate Supervision & Security: To immediately secure the dining room exit door and the outside gate, a dedicated staff member is now stationed at this location as of 11 a.m. - 03/13/26. Assigned employees are, and will continue to provide, 24/7 direct visual monitoring of these exits through the weekend and until the installation of the keypad door locks are installed and tested to prevent any unauthorized egress.Permanent Physical Correction: Permanent commercial keypad locks are scheduled for installation on the dining room exit door on Tuesday, March 17, 2026.Mandatory Staff Training: An all-staff in-service training regarding elopement prevention will be completed by 11:59 p.m. 03/13/26.On 03/16/26, the IJ was lifted, effective 03/13/26, when all components of the plan of removal had been verified as completed. A staff member was observed posted at the dining room exit door. Staff coverage schedules and in-service training regarding elopement prevention were reviewed. Staff were interviewed to ensure the in-service training had been completed. The elopement book was observed up to date.b. provide supervision, reassess the resident's fall risk, investigate to determine the root cause, and implement interventions to aid in the prevention of further falls for a resident with a history of falls for 1 (#47) of 3 sampled residents reviewed for falls. As a result, the resident sustained seven falls in five months which resulted in two separate fractures.The facility identified eight residents who were at high risk for falls.Resident #47 had falls without injury on 06/04/25, 06/05/25, 06/18/25, 06/30/25, and 07/31/25. There were no fall prevention interventions documented for any of the falls.Resident #47sustained a fall on 09/25/26 and due to pain, they were transported to the emergency room which resulted in a diagnosis of a right hip fracture that required surgical repair.Resident #47 sustained a subsequent fall on 10/19/25 that resulted in a second (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	fracture of the right hip. There was no documentation of interventions in place to prevent the fall on 10/19/25.On 04/27/26 at 10:44 a.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 04/27/26 at 12:48 p.m., the administrator and DON were notified of the IJ situation and provided the IJ template. On 04/27/26 at 4:52 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Plan of Removal - F689 (Accidents/Supervision) Immediate actionsResident #47 was reassessed by licensed nursing staff. The IDT completed a root cause analysis of prior fall events and updated individualized fall-prevention interventions, which are now in place.Similarly-Situated ResidentsThe DON or designee audited current residents with a history of recurring falls or elevated fall-risk diagnoses to confirm appropriate fall-prevention interventions are in place. Any gaps were corrected at the time of the audit. Education will be completed by 11:59 p.m. 4/27/26 [sic] for all required staff present. Any required staff member absent on 4/27/26 [sic] will receive education prior to resuming care plan responsibilities upon their return.EducationNursing staff received re-education from the DON or designee on the facility's fall prevention awareness, and timely implementation of individualized interventions. Nursing staff received educated and training regarding how to find interventions for fall prevention and where they are located within the EMR and the care plan specifics for fall prevention for each resident. Education will be completed by 11:59 p.m. 4/27/26 [sic] for all required staff present. Any required staff member absent on 4/27/26 [sic] will receive education prior to resuming care plan responsibilities upon their return.On 04/28/26, the IJ was lifted, effective 04/27/26, when all components of the plan of removal had been verified as completed. Staffing coverage schedules and in-service training regarding fall prevention interventions were reviewed. Staff were interviewed to ensure the in-service training had been completed. Care plans and care plan audits were reviewed to ensure they were updated to reflect current fall interventions.The deficient practice remained at a pattern with no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings: 1. An elopement evaluation for Resident #92, dated 02/28/26, showed the resident was a new admit and was at risk for elopement and wandering. The evaluation showed the resident wandered around the facility into rooms. A baseline care plan for Resident #92, dated 02/28/26, showed no interventions for wandering or a risk for elopement. An admission assessment for Resident #92, dated 03/06/26, showed resident's cognition was moderately impaired, with a BIMS score of 09. The assessment showed diagnoses which included schizophrenia and seizure disorder. An incident report for Resident #92, dated 03/07/26, showed the resident was reported missing from their room around 11:20 a.m. The report showed the resident was found a couple of blocks from the facility and was back in the facility by 11:30 a.m. The report showed the resident had a fall while outside the facility. The report showed the resident was placed on one-on-one staff supervision, and their care plan was updated. A progress note for Resident #92, dated 03/07/26 at 11:54 a.m., showed the resident was missing from their room around 11:20 a.m. and was found a couple of blocks from the facility. The note showed the resident tripped and fell while outside and obtained abrasions to the top of the right hand and left knee, which required first aid. The note showed the resident reported they were going to the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	bank. On 03/11/26 at 1:20 p.m., Resident #92 was observed lying in bed. A staff member was observed seated outside the resident's door. On 03/11/26 at 1:21 p.m., Resident #92 stated they were not allowed to leave the facility alone at this time. On 03/12/26 at 12:46 p.m., Resident #92 was observed in bed with no staff supervision. On 03/12/26 at 12:48 p.m., Resident #92 was observed to walk out of their room toward the dining room. No staff supervision was observed. On 03/12/26 at 12:49 p.m., an unidentified staff member was observed to walk around the corner, saw Resident #92 walking down the hall, and alerted the charge nurse the resident had left their room. On 03/12/26 at 3:15 p.m., CNA #5 stated Resident #92 was on one-on-one supervision after the elopement. CNA #5 stated the resident was not on frequent checks before the elopement due to not being an elopement risk. CNA #5 stated Resident #92 had talked about wanting to go home. On 03/12/26 at 3:28 p.m., the DON stated they believed the resident had exited the facility through the perimeter fence gate that was not locked in the smoking area. The DON stated they had not viewed camera footage to confirm how the resident exited the facility. The DON stated the resident was found a half block from a busy four-lane road. On 03/13/26 at 8:30 a.m., the exit door in the dining room and the outside perimeter gate were observed to be unlocked and accessible to residents. The unlocked gate gave access to a busy four-lane road less than one block away. On 03/13/26 at 8:45 a.m., CMA #4 stated there were residents in the facility who wandered and were at risk of elopement. CMA #4 stated they kept a close eye on them. CMA #4 stated they had not had an elopement in about a year, before Resident #92 eloped. On 03/13/26 at 8:56 a.m., the DON stated they believed the resident exited the facility through an unlocked exit door in the dining room and out an unlocked perimeter gate in the smoking area behind the facility. On 03/13/26 at 9:30 a.m., the administrator stated the fire marshal had instructed the facility they were not allowed to put a lock on the outside perimeter gate due to it being a fire safety concern. The administrator stated the dining room exit door was not secured. On 03/13/26 at 12:45 p.m., ADON #1 stated the baseline care plan did not have an intervention for elopement/wandering risk because they had failed to speak with the weekend RN who had done the elopement evaluation. ADON #1 stated they were unaware the resident was at risk for elopement. ADON #1 stated they had been told the gate to the perimeter fence could not be locked due to fire safety. An undated Wandering policy, read in part, The facility will ensure that the safety of residents who wander is maintained, and that wandering is prevented.The MDS nurse will complete an assessment (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	for wandering on all residents at admission. The MDS nurse will work with the care plan team to develop, maintain, and update a care plan for each resident who wanders. 2. A facility policy titled Falls - Clinical Protocol, dated 03/2018, read in part, The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. An incident note for Resident #47, dated 09/25/25, showed they had a fall and complained of severe pain to their right leg. The note showed they were transported to the emergency room. A nurse's note for Resident #47, dated 10/01/25, showed they had returned from the hospital. The nurse's note showed Resident #47 had sustained a right hip fracture that required surgical repair from their fall on 09/25/25. A review of Resident #47's care plan, dated 07/31/25, showed no fall prevention interventions were in place for their fall on 09/25/25. A care plan for Resident #47, dated 10/06/25, showed they were admitted to the facility on [DATE] with diagnoses which included vascular dementia and muscle weakness. The care plan showed they had falls without injury on 06/04/25, 06/05/25, 06/18/25, 06/30/25, and 07/31/25. There were no fall prevention interventions documented for any of the falls. The care plan showed Resident #47 had a BIMS of 15, which indicated they were cognitively intact. A nurse's note for Resident #47, dated 10/20/25, showed the resident had fall on 10/19/25 that resulted in a second fracture of the right hip. There was no documentation of interventions in place to prevent the fall on 10/19/25. On 03/12/26 at 1:15 p.m., Resident #47 was observed to sit in a geriatric chair near the nurse's station. A fall mat was observed on the floor next to Resident #47's bed. On 03/12/26 at 1:35 p.m., CNA #7 was observed to assist Resident #47 to a standing position from their geriatric chair. Resident #47 was observed to ambulate with their walker. On 03/12/26 at 1:15 p.m., Resident #47 stated they fell frequently and were not sure why. They stated the staff followed them everywhere to prevent falls. Resident #47 stated they were not sure what fall prevention interventions were in place for them. On 03/13/26 at 11:52 a.m., LPN #4 stated Resident #47 had fallen on 10/19/25 trying to stand up from their chair. They stated due to the amount of pain Resident #47 was complaining of, they were transported to the emergency room and diagnosed with a right hip fracture. LPN #4 stated Resident #47 required surgical repair of their right hip fracture. They stated Resident #47 had frequent falls and interventions that were in place were to use a fall mat at bedside and keep them under close observation. LPN #4 could not clarify what close observation included. LPN #4 stated interventions were given verbally by other staff as there were none in Resident #47's care plan. On 03/13/26 at 12:40 p.m., LPN #3 stated they knew what fall prevention interventions were in place for residents by looking at the resident's care plan. They stated if the interventions were not on the care plan they would have to rely on another staff member to tell them what interventions were needed for a resident. LPN #3 stated Resident #47 was seated near the nurse's station since their (continued on next page)

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	375510	A. Building B. Wing	04/28/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	second hip fracture caused by falling. On 03/13/26 at 12:50 p.m., the MDS coordinator stated all falls, regardless of injury, should receive an intervention on their care plan to prevent reoccurrence. They stated they did not know why Resident #47's falls did not have interventions. On 03/13/26 at 1:32 p.m., the DON stated there were no interventions for Resident #47's falls on their care plan and there should have been to prevent subsequent falls. An undated policy titled Care Plan Completion, read in part, The facility will develop a Comprehensive Person-centered Care Plan for each resident within 7 days after completion of the comprehensive assessment that includes: Measurable objectives and timeframes to meet resident's medical, nursing, mental, and psychosocial needs. Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure sufficient/competent staff to assess, monitor, and intervene for a resident with profuse bleeding for 1 (#96) of 1 sampled resident reviewed for a change in condition when facility staff failed to assess, monitor, intervene for significant change in condition when a resident experienced an acute onset of profuse bleeding and failed to notify the medical provider of a critical hemoglobin lab value of 6.3 with a normal reference range of 13.7 to 17.5, and the onset of profuse bleeding on a resident with a known history of encounter for surgical aftercare following surgery on the circulatory system and the presences of an aortocoronary bypass graft resulting in the subsequent death of Resident #96.Specifically, the facility failed to:a. Identify, monitor, intervene, and provide continued assessments for Resident #96 who was admitted with known history of encounter for surgical aftercare following surgery on the circulatory system and the presences of an aortocoronary bypass graft,b. Notify the medical provider of or intervene for Resident #96's critically abnormal lab value of a critical hemoglobin lab value of 6.3, and c. Notify the medical provider of or intervene for the acute onset of profuse bleeding.These failures led to the attempted transfer of Resident #96 to an acute care hospital who ultimately expired in the ambulance. The administrator identified 80 residents resided in the facility.On [DATE] at 5:24 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On [DATE] at 5:37 p.m., the administrator and DON were verbally notified of the IJ and were provided the IJ template via email at 5:57 p.m.On [DATE] at 2:23 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Immediate Jeopardy Removal Plan - F726 (Sufficient/Competent Staff) Immediate Resident Protection The facility immediately evaluated all residents and ensured that competent licensed nursing staff were assigned to provide care. Corrective Actions Implemented: Competency education includes clinical scenario-based questioning and assessment of clinical response to changes in condition. The facility implemented a standardized expectation that all licensed nurses must assess, monitor, and intervene for any change in condition. Non-clinical staff were educated about identifying visual injuries or signs of resident distress and to report to nursing staff. Staff Education The facility initiated education by the DON or Designee about recognizing and responding to changes in condition, including active bleeding. Education included requirements for assessment, ongoing monitoring, and timely physician notification. The POR will be completed by [DATE]. Staff trained by [DATE] any unavailable staff will receive training before returning to work.On [DATE] the IJ was lifted when all components of the plan of removal had been verified as completed. A review of competency education, recognizing and responding to changes in condition, ongoing monitoring, and timely physician notification for licensed staff was conducted, and licensed staff were interviewed to ensure education had been completed. A review of education for non-clinical staff for identifying visual injuries or signs of a resident in distress, and to report it to nursing staff, was conducted. Non-clinical staff were interviewed to ensure education was provided. A review of the change in condition protocol was conducted. An in-service training provided for notification of changes was reviewed, and staff were interviewed to ensure the in-service training was completed. The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings: A policy titled, Acute Condition Changes - Clinical Protocol, dated 03/2018, read in part, The physician will help identify individuals with a significant risk for having acute changes of condition during their stay. In addition, the nurse shall assess and document/report the following baseline information: a. Vital signs: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Lawton Post Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Northwest Fort Sill Blvd Lawton, OK 73507	

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Neurological status; c. Current level of pain, and any recent changes in pain level; d. Level of consciousness; e. Cognitive and emotional status; f. Resident's age and sex; g. Onset, duration, severity; h. Recent labs; i. History of psychiatric disturbances, mental illness, depression, etc.; j. All active diagnoses; and k. All current medications. Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident and how to communicate these changes to the Nurse. The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). A physician order, dated [DATE], showed: a. Eliquis (anticoagulant) 2.5mg twice a day, and b. anticoagulant medication - Monitor for discolored urine, black tarry stools, sudden severe headache, nausea/vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, and nose bleeds each shift. An admission assessment, dated [DATE], showed Resident #96's cognition was moderately impaired with a BIMS score of 11. The assessment showed the resident required supervision with ambulation and transfers. The assessment showed the resident required partial to moderate assistance with toileting hygiene. A care plan, dated [DATE], showed Resident #96 was on anticoagulant therapy r/t atrial fibrillation. The care plan showed to monitor/document/report PRN adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, and loss of appetite. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A South hall assignment sheet, dated [DATE], showed the 7:00 p.m. – 7:00 a.m. charge nurse was ACMA #2. A North hall assignment sheet, dated [DATE], showed the 7:00 p.m. – 7:00 a.m. charge nurse was LPN #1. An EMS report for Resident #96, dated [DATE], showed EMS was dispatched by the facility at 3:12 a.m. and arrived at the facility at 3:20 a.m. The report showed facility staff reported Resident #96 had experienced some blood in the stool starting three hours prior. The report showed the resident was recovering from abdominal aortic aneurysm surgery. The report showed the resident's room had signs of a significant hemorrhagic event, with towels in the corner of the room saturated with blood, and blood on the floor in various spots. The report showed the resident was on the toilet, unconscious, breathing, had blood on their socks, blood down their legs, and blood in/on the toilet. The report showed the resident left the building on [DATE] at 3:35 a.m. with EMS for transport to the hospital, and expired in the ambulance while still in the facility parking lot at 3:40 a.m. Progress notes reviewed for Resident #96, dated [DATE], did not show significant change in condition, and did not show an assessment, monitoring, or intervention was conducted for the resident's shortness of breath, screaming, blood in the toilet, and refusal to be transported to the hospital on [DATE]. A progress note, dated [DATE], showed LPN #1 was notified at 1:32 a.m. Resident #96 had increased anxiety, was screaming they could not breathe, was on the toilet, and most of the contents in the toilet were blood. The note showed the resident was educated about the need to go to the emergency department and refused. The note showed the resident became confused, EMS was contacted and arrived at 3:15 a.m., and left the facility with the resident at 3:35 a.m. On [DATE] at 2:45 p.m., family member #1 stated they were not contacted by the facility about the change in condition for Resident #96. Family member #1 stated they were not notified of the resident's passing until [DATE] at 8:46 a.m. Family member #1 stated Resident #96's room was on the south hall. On [DATE] at 10:29 a.m., LPN #1 stated they were the only licensed nurse in the building when they worked on the weekend. LPN #1 stated they did not go to the South hall to get a full report since ACMA #2 was the employee in charge to monitor residents for the hall. LPN #1 stated they would go to the South hall for falls, general questions, or concerns. On [DATE] at 10:43 a.m., LPN #1 stated ACMA #2 reported Resident #96 was screaming, hurting, pooping, and there was blood. LPN #1 stated they were told the resident was there after an abdominal aortic aneurysm, and they were concerned about the resident bleeding out. LPN #1 stated they instructed ACMA #2 to send the resident to the hospital, but the resident kept refusing. LPN #1 stated they received a text that showed a picture of the blood from ACMA #2 at 2:25 a.m. LPN #1 stated they were traumatized by the amount of blood. LPN #1 stated they had not assessed and monitored the resident because they were behind on their work, and ACMA #2 was monitoring the resident and reporting to them. On [DATE] at 11:10 a.m., LPN #1 stated it was not the standard operating procedure for the AMCA to assess, monitor, and send a resident out to the hospital. LPN #1 stated they had been late to work and were behind on their duties. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:22 a.m., ACMA #2 stated they were working as the charge for South hall on the 11:00 p.m. – 7:00 a.m. shift on [DATE]. ACMA #2 stated they were scheduled from Thursday through Sunday each week as the charge nurse for the one end of the facility because the LPN charge nurse could not be on both ends. ACMA #2 stated they were to contact the LPN working the other hall about anything above their scope of practice. ACMA #2 stated on [DATE] at 1:15 a.m., the resident was on the toilet and bleeding, their vital signs were within normal limits, and they refused to go to the ER. AMCA #2 stated they contacted LPN #1 on duty about the resident's condition and refusal to go to the ER. AMCA #2 stated the resident was back in bed when LPN #1 came to the room at 1:32 a.m. to check on the resident. ACMA #2 stated they had left the blood in the toilet for the LPN to observe. ACMA #2 stated LPN #1 told them to continue to monitor the resident since they had refused to go to the ER. ACMA #2 stated the resident was on the toilet again at around 2:00 a.m., so they texted LPN #1 and were instructed to contact the family to see if they could get the resident to go to the ER. ACMA #2 stated they were not able to find a phone number for the resident's family. ACMA #2 stated at 2:50 a.m. that the resident was again on the toilet, was still passing blood, had pain, declined pain meds, and declined to go to the hospital. AMCA #2 stated the resident became pale, was shivering, and they called 911. ACMA #2 stated that when EMS arrived, the resident was back on the toilet and had passed out. ACMA #2 stated LPN#1 only went to the resident's room one time to assess them at 1:32 a.m. On [DATE] at 4:53 p.m., the administrator stated the annual skills competencies were kept online and they would provide a copy for LPN #1 and ACMA #2. On [DATE] at 5:25 p.m., the DON stated they were unable to find annual skills competencies for LPN #1 or ACMA #2.

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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 and interview, the facility failed to store and distribute food and ice in accordance with professional standards for food service safety for 2 of 2 kitchen observations. The administrator identified 80 residents resided in the facility. Findings: On 03/10/26 at 9:46 a.m., the initial tour of the kitchen with the dietary manager was conducted with the following observations made:a. one white paper bowl with orange ice cream wrapped in plastic wrap unlabeled and undated;b. one bag of opened hamburger buns unlabeled and undated; andc. ice machine with pink substance on the white plastic chute directly above the ice, that when wiped with a clean paper towel, resulted in pink and brown speckled substance. On 03/10/26 at 10:00 a.m., the dietary manager stated the food should be labeled. They stated they saw dirt on the towel used to wipe the ice machine chute. They stated the ice machine was wiped down last week and serviced recently. On 03/11/26 at 11:21 a.m., cook #1 was observed to have one hand gloved and one hand ungloved. [NAME] #1 used the gloved hand to place cornbread into the blender, then touched the blender, utensil, and back to the cornbread to place it in the blender. [NAME] #1 did not change gloves or perform hand hygiene between touching the cornbread and the other surfaces. On 03/11/26 at 11:25 a.m., cook #1 was observed to pour the pureed food into a pan on the steam table, and take the blender to the dishwasher with the same gloved hand. [NAME] #1 removed the glove and washed their hands. On 03/11/26 at 11:29 a.m., cook #1 stated the process for changing gloves was when they changed the type of food and after touching utensils. [NAME] #1 stated they did not change gloves after touching the cornbread. On 03/11/26 at 11:32 a.m., the dietary manager stated the process for changing gloves was to change when they touched something or something was dirty. On 03/11/2026 at 12:31 p.m., DON #2 stated they did not have a policy for food storage or ice machine. They stated for maintenance of the ice machine they would wait for the machine to tell them when it was time to be cleaned and then they would call the company to come clean it. Invoices were provided to show the ice machine was serviced on 02/01/25, 03/26/25, 06/27/25, and 10/25/25. There were no recent invoices for cleaning or maintenance for 2026 provided. On 03/11/26 at 2:04 p.m., the owner of the facility stated they had the ice machine serviced last week and they must have been looking in the 2025 binder. The owner stated they would check for the most recent invoice and provide to the survey team. There were no recent invoices provided by end of survey.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate documentation for 1 (#96) of 2 sampled residents reviewed for death. The administrator identified 80 residents resided in the facility. Findings: An undated policy titled Nursing Documentation, read in part, Chart as soon as possible after giving care. Enter the date and time you are actually charting, and at the beginning of the entry - late entry for (date and time charting about).An admission assessment for Resident #96, dated [DATE], showed the resident's cognition was moderately impaired with a BIMS score of 12. The assessment showed Resident #96 required partial to moderate staff assistance with most activities of daily living.An EMS report for Resident #96, dated [DATE], showed the resident expired in the ambulance on [DATE] at 3:40 a.m.A task log for Resident #96, dated [DATE] and [DATE], showed the resident received assistance with activities of daily living on [DATE] at 10:08 a.m. The log showed the resident received assistance with activities of daily living on [DATE] at 6:54 a.m., 8:32 a.m., and 11:59 p.m.A progress note for Resident #96, dated [DATE], showed at 1:32 a.m., the nurse was notified the resident was having increased anxiety, was on the toilet, screaming he could not breathe, oxygen saturation was 98%, and most of the toilet contents were blood. The progress note was not documented as a late entry.On [DATE] at 11:54 a.m., CNA #4 stated if a resident was not in the facility, the task for the scheduled activity of daily living should be documented in the medical record as not available.On [DATE] at 12:00 p.m., RNC #1 stated if a resident passed away on [DATE], staff should not have documented a task completion on [DATE]. RNC #1 stated a task should be documented as not applicable if it still showed as scheduled for the resident.