STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375520	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Nursing Center	2801 Northwest 61st Street Oklahoma City, OK 73112

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure an allegation of abuse/mistreatment was reported to the appropriate licensing board in a timely manner for 5 (#23, 40, 53, 72, and #77) of 6 sampled residents reviewed for abuse.The administrator identified 62 residents resided in the facility.Findings:An ABUSE, NEGLECT, EXPLOITATION AND MISAPPROPRIATION OF PROPERTY PROHIBITION policy, dated 2022, read in part, The Health Care Center establishes and implements mechanisms for reporting, investigating, and monitoring the abuse, neglect and misappropriation of property prohibition.1. An annual resident assessment, dated 05/23/25, showed Resident #23 had diagnoses which included weakness and morbid severe obesity due to excess calories. The assessment showed the resident's cognition was intact with a BIMS of 15. 2. An annual resident assessment, dated 06/04/25, showed Resident #40 had diagnoses which included unspecified hearing loss, unspecified ear and repeated falls. The assessment showed the resident had severe cognitive impairment with a BIMS of 00. 3. An annual resident assessment, dated 06/22/25, showed Resident #53 had diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The assessment showed the resident had severe cognitive impairment with a BIMS of 01. 4. A discharge return not anticipated resident assessment, dated 03/31/25, showed Resident #72 had a diagnosis which included anxiety disorder. The assessment showed the resident's memory was ok. 5. A modification of end of PPS resident assessment, dated 01/15/25, showed Resident #77 had moderate cognitive impairment with a BIMS of 09.A care plan, revised 01/20/25, showed Resident #77 had diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.An Initial INCIDENT REPORT FORM, dated 01/15/25, showed an allegation of abuse/mistreatment. The report showed on 01/15/25, (staff name withheld) reported allegations of physical and emotional abuse to residents by CNA #5. The report showed CNA #5 was rolling roughly into the wall and slammed Resident #72's food tray down in front of them.The initial incident report form did not document the nurse aide registry was notified of the abuse/mistreatment allegation.A final INCIDENT REPORT FORM, dated 01/17/25, showed an allegation of abuse/mistreatment. The report showed CNA #5 was rolling Resident #23 and Resident #40 roughly into the wall with unprofessional comments and slammed Resident #72's food tray down in front of them. The report showed other residents involved were Resident #53 and Resident #77. The report showed the nurse aide registry was notified of the abuse/mistreatment allegation.The report Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property, dated 01/17/25, showed CNA #5 was reported for abuse/mistreatment allegation.On 07/22/25 at 10:45 a.m., the administrator stated the nurse aide registry should have been notified of the abuse/mistreatment allegation by CNA #5 when the initial incident form was reported to the state agency on 01/15/25.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure notification of a bed hold was provided upon transfer for 1 (#73) of 4 sampled residents who were reviewed for hospitalization.The administrator identified 62 residents resided in the facility.Findings:The admission assessment, dated 02/20/25, showed Resident #73 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of end stage renal disease. An entry under the Census section of the electronic clinical record, dated 04/05/25 through 06/15/25, showed Resident #73 was a long-term care resident. A physician order, dated 06/15/25, showed Resident #73 was transferred to the emergency room to be evaluated and treated. A progress note, dated 06/15/25, did not show notification of a bed hold had been provided. On 07/22/25 at 2:46 p.m., LPN #1 stated the administrator or social services director provided bed hold information when a resident was transferred to the hospital. On 07/23/25 at 8:30 a.m., LPN #4 stated they did not know who provided notification of a bed hold upon transfer to the hospital. They stated they thought it was the administrator or the social services director. On 07/23/25 at 8:37 a.m., the administrator stated residents signed information regarding bed holds upon admission. They stated the facility did not provide notification regarding bed holds at the time of a transfer to the hospital.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interview, the facility failed to ensure an annual comprehensive assessment was completed within 366 days of the previous annual comprehensive assessment for 1 (#9) of 19 sampled residents whose assessments were reviewed.The administrator identified 62 residents resided in the facility. Findings: An annual assessment, dated 11/18/24, showed Resident #9 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and a diagnosis of diabetes mellitus. The annual assessment showed it was completed on 12/13/24. An MDS 3.0 NH Final Validation Report, dated 12/13/24, showed the annual assessment for Resident #9, read in part, Assessment Completed Late: An OBRA comprehensive assessment with the Care Area Assessment [Section V] is due every year unless the resident is no longer in the facility. A prior record with an ARD [A2300] within 366 days of the submitted record could not be found. On 07/23/25 at 6:13 p.m., the administrator stated they had not had an MDS coordinator,. They stated they were utilizing the corporate MDS coordinator and assessments were completed late.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to provide bathing for 1 (#41) of 6 sampled residents reviewed for activities of daily living.The administrator identified 43 residents required assistance with bathing. Findings:An undated facility policy titled Resident Showers, read in part, Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.Resident #41's admission resident assessment, dated 05/29/25, showed the resident had impairment on one side of their upper and lower extremity. The assessment showed the resident required partial to moderate assistance with bathing with the assistance of one person. The assessment showed Resident #41's cognition was intact with a BIMS of 15.A care plan, dated 06/05/25, showed Resident #41 had diagnoses which included cerebral infarction and obesity.A Documentation Survey Report for July 2025 showed Activity itself did not occur or family and/or non facility staff provided care 100% of the time for that activity on:a. 07/05/25,b. 07/12/25, andc. 07/19/25.Resident #41 was identified during resident group meeting held on 07/18/25 at 11:16 a.m. of not receiving their showers as scheduled.On 07/23/25 at 11:53 a.m., CNA #3 stated they looked in the shower book to determine which resident were scheduled for a shower.On 07/23/25 at 11:54 a.m., CNA #3 stated if a resident declined a shower, they informed the nurse, the DON, and administrator. They stated they would document refusal on the shower sheet.On 07/23/25 at 11:56 a.m., CNA #3 stated they would document activity did not occur if the shower was not provided or if the resident refused.On 07/23/25 at 11:57 a.m., CNA #3 stated Resident #41 never refused a shower.On 07/23/25 at 11:58 a.m., CNA #4 stated Resident #41's shower scheduled was every Tuesday, Thursday, and Saturday.On 07/23/25 at 11:59 a.m., CNA #4 stated Resident #41 never refused a shower.On 07/23/25 at 12:10 p.m., the DON stated they could not locate any shower sheets for the above dates to show the resident refused a shower.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to ensure a resident:a. received appropriate care for a dehisced surgical incision for 1 (#54) of 4 sampled residents reviewed for hospitalization; andb. had an order for hospice services for 2 (#75 and #4) of 3 sampled residents reviewed for hospiceThe administrator identified 62 residents resided in the facility and 11 residents received hospice services.Findings: 1. Resident #54's significant change resident assessment, dated 06/26/25, showed the resident had diagnoses which included unspecified fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing and limitation of activities due to disability. The assessment showed the resident had moderate cognitive impairment with a BIMS of 10. A physician progress note, dated 07/04/25, showed the resident had a long right lateral knee incision which had multiple dehisced areas. The note showed they would have the staff contact the surgeon's office to make sure they know about the dehisced areas. There was no documentation the facility contacted Resident #54's surgeon to notify them about the dehisced surgical site. A Daily Skilled Nurses Note dated 07/05/25, did not document the resident's surgical site was dehisced. A nursing note, dated 07/13/25 at 9:22 a.m., showed the resident pulled out their trach and was sent to the emergency room for further eval. A nursing note, dated 07/13/25 at 10:30 a.m., showed the resident was observed taking off the dressing from their wound and picking on it with blood in their hands. The note showed the nurse replaced the wound dressing. A hospital record, dated 07/13/25, showed the resident had evidence of wound dehiscence to their surgical site. The record showed the resident had a procedure for the closure of the wound dehiscence on 07/14/25. On 07/17/25 at 2:50 p.m., LPN #3 stated they were familiar with the resident's care. They stated they last cared for the resident on 07/10/25. They stated the resident's surgical site was not open. On 07/18/25 at 12:35 p.m., LPN #2 stated they took care of the resident on 07/08/25. They stated the resident's surgical site was not open. On 07/22/25 at 8:20 a.m., RN #1 stated the first time they noticed the resident's surgical site had opened was on 07/13/25. They stated they cared for the resident on 07/12/25 and the surgical site was not open. On 07/22/25 at 11:40 a.m., the corporate nurse consultant stated the DON was responsible for reviewing physician progress notes. They stated the current DON had started working at the facility on 07/09/25 which was the day they received the 07/04/25 physician progress note. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/25 at 11:43 a.m., Corporate Nurse Consultant #1 stated the facility should have clarified the physician progress note dated 07/04/25. On 07/22/25 at 11:43 a.m., Corporate Nurse Consultant #1 stated the facility should monitor surgical sites and notify the physician if the site dehisced. 2. A policy titled Hospice Services Facility Agreement, dated 04/14/24, read in part, The facility has the interdisciplinary team to be responsible for working with hospice representatives to coordinate care to the resident provided by facility and hospice staff. A progress note, dated 03/19/25, showed Resident #75 wanted to switch hospice companies. A physician order, dated 03/21/25, showed the resident was ordered to be evaluated by the resident's chosen hospice. A significant change assessment, dated 05/16/25, showed Resident #75 had a BIMS score of 12, which indicated the resident was moderately impaired in cognition for daily decision making, and had a life expectancy of less than six months. On 07/23/25 at 6:00 p.m., the administrator was asked when Resident #75 had been originally admitted to hospice services. They stated they did not have an order for the first hospice Resident #75 had been admitted to in February or March 2025, or the hospice company's hard chart. They stated they had coordinated care with the second hospice company Resident #75 had switched to. They stated the first hospice company would routinely make visits to the facility to see the resident between 7:00 p.m. and 11:00 p.m. so there was not a coordination of care with that hospice company. 3. An initial hospice assessment, dated 03/19/25, showed Resident #4 had been assessed by the RN with the hospice company. A significant change assessment, dated 06/11/25, showed Resident #4 had a BIMS score of 14, which indicated the resident was cognitively intact for daily decision making, and had a life expectancy of less than six months. A care plan, reviewed 06/30/25, showed a focus related to hospice services had been initiated on 06/20/25. On 07/18/25 at 8:13 a.m., review of the clinical record did not show Resident #4 had a physician's order for hospice services. A physician order, dated 07/18/25 at 10:54 a.m., showed Resident #4 was admitted to hospice services on 03/19/25. On 07/21/25 at 2:51 p.m., the DON stated they had entered the physician order for hospice services for Resident #4 because there had not been one put into the electronic clinical record. The DON stated they did not know why Resident #4 had not had an order for hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/25 at 4:19 p.m., LPN #4 stated they would review the physician orders to determine if a resident was to receive hospice services. They stated if the resident did not have an order for hospice, they would know the resident was on hospice because the hospice companies had hard charts for the residents on services.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure an accident did not occur for a resident during facility transport for 1 (#7) of 1 sampled resident reviewed for accident hazards. The administrator identified eight residents used the facility van for transportation. Findings:On 07/17/25 at 10:59 a.m., the maintenance supervisor demonstrated the process of preparing a resident for transport per wheelchair using the facility van. There were four straps to be connected to the wheelchair at all sides. An undated form titled Policy and Procedure Securing a Wheelchair For Van Transport, read in part, Safety is the top priority when transporting wheelchair users in a wheelchair van. Position the wheelchair in the van as close as possible to the safety straps bolted in the floor. Check that the wheelchair's locks are in place and that four straps with hooks are bolted on the floor, as well as the regular seat belt that goes around the person who is in the wheelchair. Put the seat belt across the individual's lap and chest and fasten it. Adjust the seat belt so that it fits comfortably.An undated face sheet showed Res #7 had diagnoses which included chronic kidney disease stage 4, schizophrenia, seizures, altered mental status, muscle weakness, and abnormalities of gait and mobility.A quarterly assessment, dated 10/15/24, showed Res #7 had a BIMS score of 14 and was not cognitively impaired. The assessment showed the resident required moderate assistance with dressing and transfers.An incident report, dated 11/29/24, showed Res #7 had certain injury. The report showed the resident was being transported to dialysis by the facility van. The report showed a seat belt was in place for transport. The report showed CNA #1 was driving the van and noticed the resident was starting to slide down out of the wheelchair. The report showed CNA #1 pulled the van over and the resident was on the floor. The report showed CNA #1 noted a laceration to the resident's right leg, EMS was called, and the resident was taken to the emergency room by EMS. A nurse note, dated 11/29/24 at 2:31 p.m., showed at 2:00 p.m. Res #7 was being transported to dialysis by facility van. The note showed the resident was observed slumped down in the wheelchair, the staff stopped the van, and the resident was lying on the van floor. The note showed Res #7 was transported by EMS. The note showed the resident received an order to return to the hospital in 10 days to remove the stitches. A nurse note, dated 12/01/24, showed Res #7 continued with focus charting for laceration with sutures to right foot.An In-service Training Report, dated 12/02/24, showed staff were educated to call for assistance and have staff accompany resident during transportation if indicated by charge nurse. A nurse note, dated 12/05/24, showed a wound to the right leg with sutures intact but draining out dark color secretion with a foul odor noted. The note showed the resident complained of pain to the wound site. On 07/17/25 at 10:38 a.m., Res #7 stated the facility provided transportation to dialysis three times a week. The resident stated the staff always placed the seat belt for transport. The resident did not recall sliding or falling out of their wheelchair during transport to dialysis. On 07/17/25 at 11:09 a.m., the maintenance supervisor stated a seat belt was placed around the resident's waist and a shoulder belt from above the left side was connected to the waist belt. The maintenance supervisor stated if the seat belt was placed correctly the resident could not fall out of the chair. On 07/18/25 at 12:10 p.m., CNA #1 was interviewed about the incident with Res #7 on 11/29/24 sliding out of the wheelchair during transport. CNA #1 stated they positioned the wheelchair and connected the straps to the wheelchair. CNA #1stated the LPN/charge nurse #1 placed the seat belt on the resident. The CNA stated they observed in the rearview mirror Res #7 sliding out of their wheelchair, they pulled the van off the road, and Res #7 was found lying on the van floor. CNA #1 stated the seat belt was still connected around the wheelchair. On 07/18/25 at 1:28 p.m., the administrator was asked was the in-service provided to staff sufficient in addressing the incident that occurred on 11/29/24 regarding Res #7 sliding out of the wheelchair during transport. The administrator stated the in-service provided did not address the concern regarding Res #7 sliding out of the wheelchair during transport. On 07/18/2025 at 2:40 p.m., the administrator stated LPN/charge nurse #1 placed the seat belt on Res #7 for transport on 11/29/24. The administrator stated the transportation driver/CNA #1 was responsible for ensuring the resident was secured correctly for transport.