STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375562	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McMahon-Tomlinson Nursing Center	2007 NW 52nd Street Lawton, OK 73505

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed to include skin integrity for 1 (#7) of 12 sampled residents whose care plans were reviewed. The administrator identified 122 residents resided in the facility. Findings: A Care Planning - Interdisciplinary Team policy, revised 2016, read in part, Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. An undated care plan for Resident #7 did not show the resident being at risk for potential/actual skin impairment. An admission assessment for Resident #7, dated 05/10/26, showed the resident had a brief interview for mental status score of 4 indicating severe cognitive impairment, dependent with toileting and hygiene, always incontinent, and was at risk for developing pressure ulcers. A nursing note for Resident #7, dated 05/27/26, read in part, Received report that [Resident #7] has skin issue upon observation noted skin abrasion to rt inner ischium measures 9.5 x .5 cm with s/s [signs and symptoms] of irritation from Brief. and chaff spot to rt buttocks measures 1.5 x .5 cm no noted drainage no c/o [complaints of] pain nor discomfort. will clean area pat dry apply thin layer of [name withheld] ointment 1:1 mix with [name withheld] wound Paste. Pt [patient] aware and agreed SN [skilled nursing] notified. On 06/19/26 at 2:44 p.m., the wound care nurse stated Resident #7 had no skin issues upon admission. They stated they were notified of the skin issues on 05/27/26 and obtained orders for an ointment and a paste. On 06/19/26 at 3:09 p.m., the minimum data set coordinator stated skin impairment was not on Resident #7's care plan. They stated Resident #7 was at risk of skin impairment, and it should have been care planned.

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure staff implemented proper infection control practices while performing incontinent care for 2 (#10 and #11) of 2 sampled residents observed for incontinent care.The director of nursing identified 68 residents required assistance with incontinent care.Findings:1.On 06/25/26 at 1:06 p.m., CNA #1 and CNA #2 were observed to knock on Resident #10's door and ask permission to enter. CNA #1 and CNA #2 donned a gown and gloves prior to entering. CNA #1 explained they were there to provide incontinent care. CNA #1 assisted with removing the blanket and sheet from the resident. CNA #2 lowered the head of the bed and raised the bed. Each CNA assisted with pulling the resident's pajama pants below their knees. Resident #10's brief was dry. CNA #1 was observed to wipe each side of the genitalia with one wipe each and disposing of the wipe. CNA #1 used one wipe to clean the resident's indwelling catheter then disposed of the wipe. CNA #1 assisted Resident #10 to their right side. CNA #2 wiped the resident's perineal area and coccyx with one wipe each and disposed of the wipes. CNA #2 wiped each buttock with one wipe and disposed of the wipes. On 06/25/26 at 1:10 p.m., CNA #1 and CNA #2 did not change their gloves after cleaning Resident #10. CNA #2 obtained a clean brief from the resident's bedside dresser. CNA #2 then placed the clean brief under Resident #10's left hip and buttock. CNA #1 and CNA #2 assisted the resident to their back. CNA #1 pulled the brief through to the right side. Each CNA assisted with fastening the brief. CNA #1 and #2 assisted the resident with pulling their pajama pants up. CNA #1 assisted the resident with pulling their shirt down and pulling the sheet and blanket up to Resident #10's chest. CNA #1 and #2 used a folded sheet under the resident to pull them up in their bed. CNA #2 gave the resident their call light and raised the bed and placed the bed remote on the bed within reach of Resident #10. CNA #2 then grabbed the bedside table and placed it next to the resident's bed. CNA #1 and CNA #2 then each removed their gloves. CNA #1 and CNA #2 sanitized their hands as exiting Resident #10's room. A Perineal Care policy, revised 02/2018, read in part, The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections. On 06/25/26 at 1:28 p.m., CNA #1 stated the facility policy for infection control was to change gloves between dirty and clean. They stated they should have changed their gloves more. CNA #1 stated they should have changed their gloves before touching all of those items after perineal care. 2. On 06/25/26 at 2:30 p.m., CNA #3 and CNA #4 were observed to wash and dry their hands. CNA #3 knocked on Resident #11's door and requested permission to enter the room. CNA #3 and CNA #4 donned a gown and gloves. On 06/25/26 at 2:38 p.m., CNA #4 informed Resident #11 they were going to provide incontinent care and indwelling urinary catheter care. CNA #3 set the bedside table as a workspace by placing a barrier then clean incontinent wipes and a clean brief. On 06/25/26 at 2:45 p.m., CNA #3 adjusted the height of the bed and lowered head of bed. CNA #3 and CNA #4 folded the bed linens down and opened the soiled brief. Resident #11 was assisted to lay on their left lateral side. CNA #4 helped Resident #11 to maintain their position while CNA #3 used incontinent wipes to clean Resident #11's buttocks area. Wipes were used for one swipe then folded to clean area and wiped another area of the buttocks until the buttocks area was clean. On 06/25/26 at 3:00 p.m., CNA #4 assisted CNA #3 with repositioning Resident #11 to laying on their (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back with their legs elevated and separated. CNA #4 assisted with holding Resident #11's legs apart while CNA #3 used incontinent wipes to clean the genitalia area. CNA #3 wiped down and away from the genitalia opening and continued this process with new wipes until the area was cleansed. CNA #3 stabilized the indwelling urinary catheter from the genitalia insertion while cleaning the catheter. On 06/25/26 at 3:08 p.m., CNA #3 grabbed a clean brief without changing their gloves and without sanitizing their hands. The brief was positioned under Resident #11 and then the brief was pulled through Resident #11's legs. CNA #4 then rolled the resident onto their left lateral side, adjusted the brief, then Resident #11 was returned to their back with their legs elevated and separated, and secured the brief. CNA #3 and CNA #4 each positioned the resident up higher into the bed and pulled the covers up on the resident. CNA #3 used the bed controls to raise the head of the bed and lowered the bed to a safe height and placed the call within reach. CNA #4 removed their gown and gloves and disposed of them into the trash can. CNA #3 removed their gown, kept their gloves on, placed their gown in the trash bag, removed the trash from the room to the trash bin. CNA #4 went to the sink to wash their hands and CNA #3 washed their hands after discarding the trash in the trash bin. On 06/25/26 at 3:15 p.m., CNA #3 and CNA #4 were asked if they should have changed their gloves while providing incontinent care for Resident #11. CNA #3 stated, Yes we should have changed our gloves after we cleaned the resident and before touching the blankets and bed remote. CNA #3 and CNA#4 were asked if they changed their gloves adequately. CNA #3 and CNA #4 stated, No.