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	12/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review, and interview, the facility failed to ensure wound care was provided per physician orders for 1 (#31) of 2 sampled residents reviewed for wound care.The DON identified 123 residents resided in the facility.Findings: On 12/10/25 at 10:50 a.m., Resident #31 was observed in bed. The resident had staples to a right above knee amputation site.An Abuse & Neglect policy, dated 01/02/22, read in part, Neglect is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.A care plan for Resident #31, dated 10/02/25, showed a pressure ulcer development related to immobility and a low Braden score to the right foot, right inner foot, right ankle, and back of right leg. The care plan showed the resident's pressure ulcer would show signs of healing and remain free from infection. The care plan showed to follow facility policies/protocols for the prevention/treatment of skin breakdown.Resident #31's treatment administration record for October 2025 showed a physician ordered wound care, dated 10/13/25, for the right foot, right ankle, and back of the right leg. The record showed to clean the area, pat dry, apply a thin layer of hydrogel (wound dressing, place Meplix (wound dressing) transfer abdominal pad, cover with Kerlix, and observe for skin condition changes to be done daily. A health status note, dated 10/13/25, showed Resident #31 had ruptured blisters to the right foot, ankle, and back of leg. The note showed hydrogel was applied, covered with Meplix and an abdominal pad, and secured with Kerlix. The note showed light drainage on discarded steri strips and dressings.A health status note, dated 10/15/25, showed Resident #31 tolerated treatment to right foot and ankle. The note showed no noted drainage and no signs or symptoms of infection.A health status note, dated 10/21/25, showed Resident #31's dressing around the right foot was soiled. The note showed the wound had a strong odor and had grown significantly in size. The note showed the wound dressing was last changed on 10/17/25. The note showed the wound care had not been performed as ordered daily on 12/18/25, 12/19/25, and 12/20/25 as documented on the resident's treatment administration record.A health status note, dated 10/21/25, showed treatment was completed to Resident #31's right lower leg extending to the ankle, and inner side of the foot. The note showed the wound bed had areas of necrotic (dead or dying) tissue, slight yellow slough (nonviable, dead tissue), and a small amount of red granulation (new, moist connective tissue) along wound edges. The note showed large fluid filled blisters noted to top of right foot, black discoloration noted to the outer side of right foot, and the lateral side of the toe. The note showed a strong foul odor noted at this time. The note showed the wound classified as stage 3 with measurements to areas noted as the following: top of right foot 8 cm x 4 cm, inner side of foot 7.5 cm x 4 cm, posterior leg to ankle 14 cm x 7.5 cm. A physician's note, dated 10/21/25, showed Resident #31 had multiple wounds to right lower extremity noted with some foul-smelling drainage noted. The note showed a culture was to be obtained, Cipro (antibiotic), and obtain bilateral lower extremity arterial ultrasound. A physician's note, dated 10/21/25, showed Resident #31 had an open wound visible on the dorsal aspect of the right foot with significant odor, and the flesh was broken down and macerated with a depth of at least 4 mm. The note showed the wound appeared to be infected with a serosanguinous bloody discharge. The note (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	showed the extremity pulses were unable to be palpated on the right lower extremity. The note showed an assessment finding to be an infected ulcerating wound of the right lower extremity, possibly due to lack of arterial blood flow and reduced pulses bilaterally. An incident report (ODH Form 283) for an allegation of neglect, dated 10/21/25, showed as of 10/01/25, Resident #31 had a stage 2 wound to the right medial foot. The report showed the wound care nurse entered the resident's room to provide wound care and the wound was then a stage 3. The report showed the wound care was ordered to be performed daily and as needed. The report showed the wound care was not performed on 10/18/25, 10/19/25, and 10/20/25 and the nurse admitted to not performing the wound care. The report showed the resident's wound progressed from stage 2 to a stage 3, indicating the wound worsened from the omission. The note showed the neglect allegation was substantiated. A doppler of the right arterial lower leg report, dated 10/22/25, showed findings were likely representing severe peripheral arterial disease with the possibility of hemodynamic significant stenosis. A health status note, dated 10/29/25, showed Resident #31 had been admitted to the hospital and was in surgery for a right below knee amputation. The note showed the resident was admitted for wounds to the right foot.A quarterly assessment, dated 11/13/25, showed Resident #31's cognition was severely impaired, and the BIMS was not able to be scored. The assessment showed the resident was dependent on staff for all activities of daily living. The assessment showed surgical wound and no pressure ulcers. The assessment showed the resident had diagnoses which included, diabetes mellitus, coronary artery disease, and absence of the right leg below the knee.On 12/15/25 at 12:19 p.m., the DON stated the finding from the investigation of the wound care not being performed for Resident #31's right foot on 10/18/25, 10/19/25, and 10/20/25 had caused worsening of the wound, and was found to be neglect by the nurse. The DON stated they could not be certain this resulted in the below-the-knee amputation the resident had on 10/29/25, since it was found the resident had severe peripheral arterial disease with significant stenosis. On 12/15/25 at 12:42 p.m., a family member stated they were told the resident had not received wound care as ordered by the physician.On 12/15/25 at 4:30 p.m., Physician #1 stated Resident #31's wound did not appear to be pressure related. The physician reported the wound appeared to be vascular and developed quickly. The physician stated they were unaware of the poor blood flow until the vascular study was performed. The physician stated they believed the missed wound care would not have mattered due to the restricted blood, and the amputation of the leg was inevitable.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to follow physician's orders and care plans to prevent the worsening of wounds for 1 (#31) of 2 sampled residents reviewed for wound care.The DON identified 123 residents resided in the facility.Findings: On 12/10/25 at 10:50 a.m., Resident #31 was observed in bed. The resident had staples to a right above knee amputation siteA Skin Assessment and Ongoing Skin Integrity Monitoring policy, dated 03/16/24, showed comprehensive skin assessment and ongoing monitoring were performed to identify risks, prevent skin breakdown, and ensure timely interventions in accordance with professional standards. The policy showed that documentation of skin assessments should reflect the location, size, appearance, intervention implemented and resident response. A care plan for Resident #31, dated 02/23/25, showed a pressure ulcer development related to immobility and a low Braden score to the right foot, right inner foot, right ankle, and back of right leg. The care plan showed a goal for the resident's pressure ulcer would show signs of healing and remain free from infection. The care plan showed to follow facility policies/protocols for the prevention/treatment of skin breakdown. The care plan showed to provide weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate.A health status note, dated 09/29/25, showed Resident #31 had chronic bruises to the right foot had been followed for weeks, the area opened, and resulted in a sore to the area. The note showed the area first appeared as bruising when the resident was noted pressing the heel of their foot against the other foot. The note showed pillows were placed to separate the feet, but the resident managed to remove the pillows and continued to place their feet in that position. The note showed discoloration and a fluid filled blister also noted to lateral side of right foot, pulse noted within normal limits, and no signs or symptoms of pain.A physician's order, dated 09/29/25, showed Hydrogel (wound dressing) to right foot, right ankle, and back of right leg every day shift for wound care. The order showed to clean areas, pat dry, apply thin layer of hydrogel, place Meplix (wound dressing) transfer abdominal pad, cover with Kerlix, and observe for skin condition changes.A Skin & Wound evaluation, dated 10/01/25, showed a new in-house acquired intact blister to right lateral foot. A Skin & Wound evaluation, dated 10/01/25, showed an in-house acquired stage 2 pressure wound to the right medial foot, present for one week. The evaluation showed measurements to be 9.7 cm x 7.1 cm x 2.4 cm from a ruptured blister. The evaluation showed treatment to be generic wound cleanser, a polymem (wound dressing) dressing, and Tegaderm (wound dressing).A Skin Observation Tool, note, dated 10/05/25, showed Resident #31's dorsal right lower extremity wound bed appeared necrotic with clear, moderate drainage. The note showed the wound required further evaluation. The note showed the physician had not been contacted for a further evaluation of the wound.A health status note, dated 10/08/25, showed Resident #31 tolerated treatment to the right back of leg and right foot. The note showed the skin to the back of the leg was hardening and drying, with no noted drainage. The note documented no weekly measurements of the wounds.A health status note, dated 10/12/25, showed Resident #31's top layer of the skin of the blisters to the right foot had peeled over. The note showed the skin to the arch of the foot was also peeled over and very little skin left to approximate. The note showed no measurements of the wounds.Resident #31's treatment administration record, dated October 2025, showed physician ordered wound care, dated 10/13/25, for the right foot, right ankle, and back of the right leg. The record showed to clean the area, pat dry, apply a thin layer of hydrogel, place Meplix transfer abdominal pad, cover with Kerlix, and observe for skin condition changes to be done daily. A health status note, dated 10/13/25, showed Resident #31 had ruptured blisters to the right foot, ankle, and back of leg. The note showed hydrogel was applied, covered with Meplix and an abdominal pad, and secured with Kerlix. The note showed light serous drainage on discarded steri strips and dressings. The note showed no measurements of the wounds.A health status note, dated 10/15/25, showed Resident #31 tolerated treatment to right foot and ankle. The note showed no noted drainage (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and no signs or symptoms of infection. The note showed no measurements of the wound.A health status note, dated 10/21/25, showed Resident #31's dressing around the right foot was soiled. The note showed the wound had strong odor and had grown significantly in size. The note showed the wound dressing was last changed on 10/17/25. The note showed the wound care had not been performed as ordered daily on 12/18/25, 12/19/25, and 12/20/25 as documented on the resident's treatment administration record.A health status note, dated 10/21/25, showed treatment was completed to Resident #31's right lower leg extending to the ankle, and inner side of the foot. The note showed the wound bed had areas of necrotic (dead or dying) tissue, slight yellow slough (nonviable, dead tissue), and a small amount of red granulation (new, moist connective tissue) along wound edges. The note showed large fluid filled blisters noted to top of right foot, black discoloration noted to the outer side of right foot, and the lateral side of the toe. The note showed a strong foul odor noted at this time. The note showed the wound classified as a stage 3 with measurements to areas noted as the following: top of right foot 8 cm x 4 cm, inner side of foot 7.5 cm x 4 cm, posterior leg to ankle 14 cm x 7.5 cm.A physician's note, dated 10/21/25, showed Resident #31 had multiple wounds to the right lower extremity noted with some foul-smelling drainage noted. The note showed a culture to be obtained, Cipro (antibiotic), and obtain bilateral lower extremity arterial ultrasound A physician's note. dated 10/21/25, showed Resident #31's had an open wound visible on the dorsal aspect of the right foot with significant odor, and the flesh was broken down and macerated with a depth at least 4 mm. The note showed the wound appeared infected with bloody discharge. The note showed the extremity pulses were unable to be palpated on the right lower extremity. The note showed an assessment finding to be an infected ulcerating wound of the right lower extremity, possibly due to lack of arterial blood flow and reduced pulses bilaterally.An incident report (ODH Form 283) for an allegation of neglect, dated 10/21/25, showed as of 10/01/25, Resident #31 had a stage 2 wound to the right medial foot. The report showed the wound care nurse entered the resident's room to provide wound care and the wound was then a stage 3. The report showed the wound care was ordered to be performed daily and as needed. The report showed the wound care was not performed on 10/18/25, 10/19/25, and 10/20/25 and the nurse admitted to not performing the wound care. The report showed the resident's wound progressed from a stage 2 to a stage 3, indicating the wound worsened from the omission. The note showed the neglect allegation was substantiated.A doppler of the right arterial lower leg report, dated 10/22/25, showed findings were likely representing severe peripheral arterial disease with possibility of hemodynamic (pressure and resistance of the blood flow) significant stenosis (constriction).A health status note, dated 10/29/25, showed Resident #31 had been admitted to the hospital and was in surgery for a right below the knee amputation. The note showed the resident was admitted for wounds to the right foot.A quarterly assessment, dated 11/13/25, showed Resident #31's cognition was severely impaired, and the BIMS was not able to be scored. The assessment showed the resident was dependent on staff for all activities of daily living. The assessment showed a surgical wound and no pressure ulcers. The assessment showed a diagnosis of diabetes mellitus and coronary artery disease, and absence of right leg below the knee.On 12/15/25 at 12:19 p.m., the DON stated the finding from the investigation of the wound care not being performed for Resident #31's right foot on 10/18/25, 10/19/25, and 10/20/25 had caused worsening of the wound, and was found to be neglect by the nurse. The DON stated they could not be certain this resulted in the below-the-knee amputation the resident had on 10/29/25, since it was found the resident had severe peripheral arterial disease with significant stenosis.On 12/15/25 at 12:42 p.m., a family member stated they were told the resident had not received wound care as ordered by the physician.On 12/15/25 at 4:30 p.m., Physician #1 stated Resident #31's wound did not appear to be pressure related. The physician stated the wound appeared to be vascular and developed quickly. The physician stated they were unaware of the poor blood flow until the vascular study was performed. The physician stated they believed the missed wound care would not have mattered due to the restricted blood, and the amputation of the leg was inevitable.On 12/16/25 at 10:28 a.m., LPN #2 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	stated they had been covering for the wound care nurse on 10/21/25. The LPN stated they had found the wound to have worsened and appeared infected. LPN #2 stated wound care had not been completed daily as ordered. LPN #2 stated they were taking measurements of the wound at that time. LPN #2 stated the physician was in the building and evaluated the wound at that time and ordered a culture and doppler.On 12/16/25 at 10:57 a.m., the ADON stated skin assessments were not done weekly. The ADON stated the wound care nurse performed skin assessments, documented changes and a description of the wound. The ADON stated the physician should have been contacted the same day the nurse documented a skin observation needed to be assessed further. The ADON stated the wound should have been evaluated before it was seen again by the wound care nurse on 10/08/25. The ADON stated if the resident's care plan reads measurements and descriptions of skin breakdown were to be documented weekly, then the skin assessment should be completed weekly.On 12/16/25 at 11:45 a.m., the wound care nurse stated they measured wounds every 1-2 weeks and took pictures of the wound and documented in the medical record. The wound care nurse stated this had not been done on Resident #31 because they had not worked a lot during the month of October. The wound care nurse stated they had documented measurements and took pictures of the wound on 10/01/25.