STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375571	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilson Nursing Center	867 US Highway 70a Wilson, OK 73463

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41872 Based on record review and interview. the facility failed to ensure the clinical health record contained an accurate code status (CPR or DNR) for one (#27) and have an Advance Directive for one (#30) of sixteen sampled residents reviewed for Advance Directives. The Administrator identified 28 residents who resided in the facility. LPN #1 identified eight residents who had a Do Not Resuscitate code status. Findings: A Facility's policy Advance Directive Policy and Procedure undated, Read in part The resident has a right to formulate an advance directive .The resident will be assessed periodically for decision-making ability capacity and for changes in resident preferences and choices .In order for a resident to exercise his or her right to make informed choices about care and treatment in preparation for a time when the resident may not be able to make decisions, designated personnel and/or physician will assist with defining and clarifying medical issues and presenting the information regarding relevant care issues to the resident or his/her legal representative, in language that the resident can understand , as appropriate . 1. Resident #27 had diagnoses which included atrial fibrillation and pain. Resident #27's electronic health record did not contain a code status and the hard chart did not contain a signed DNR. On [DATE] at 9:38 a.m., the IPC nurse was asked what was Resident #27's code status. They stated, I am pretty sure [Resident #27] is a full code but there is no order. The SSD stated, Resident #27 was a DNR. They reviewed Resident #27's hard chart and stated they were unable to find a copy of the DNR. The hard chart was observed to have a white sticker on the spine of the chart that documented DNR. On [DATE] at 9:43 a.m., Resident #27 was observed laying in their bed. They were asked what their code status was. They stated they were a DNR. 46653 (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #30 had a diagnosis of Dementia. On [DATE] at 9:42 a.m. , documentation of Resident #30 advance directives reported that on [DATE] that it would be reviewed at a later date and no follow-up was found. On [DATE] at 9:43 a.m. , the Social Services Director reported that Resident #30 representative did not have a living will or Do Not Resuscitate order at the time of admission. On [DATE] at 9:44 a.m. , the Social Services Director reported that if Resident # 30 had an emergency we would have nothing to follow through in case of an medical emergency and we have no follow-up.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41872 On 07/29/24 at 5:06 p.m., the Oklahoma State Department of Health identified the presence of an immediate jeopardy related to physical and sexual abuse. Resident #3 had multiple progress note entries that documented resident to resident physical abuse (hitting) and resident to resident sexual behaviors (rubbing/touching the groin areas of male residents, using male residents hands to rub their breast, and rubbing on other residents.) All Residents involved with the inappropriate touching had moderate to severe cognitive impairment. On 07/29/24 at 5:10 p.m., the Administrator was notified of the presence of an immediate jeopardy related to abuse. A plan of removal was requested. On 07/30/24 at 4:52 p.m., the following POR for abuse was submitted to OSDH for review: A [Name of Facility Withheld] Plan of Removal, dated 07/30/24, read in parts .Step #1 CORRECTIVE ACTIONS: Upon notification of the deficient practice, immediate action was taken to protect residents at risk from abuse from Resident #3 which could result in psychosocial harm due to sexual touching and serious injury or harm from physical abuse. Within one hour of receipt of the IJ, an agreement was made between the facility and [Name of Hospital withheld] to take Resident #3 for evaluation and treatment to immediately remove any threat of harm. Resident #3 was taken to the hospital by [family member] at 19:30 [7:30 p.m.]. [Name of Hospital withheld] agreed to keep the resident overnight and to transfer [them] to [Name of hospital withheld] for evaluation and treatment at [Name of hospital withheld] . Staff responsible for reporting and documenting suspected abuse will receive additional training. The Care Plan for Resident #3 will be updated by 07/30/2024 to reflect behavioral issues and necessary interventions. Step #2 IDENTIFICATION OF OTHERS WITH THE POTENTIAL OF BEING AFFECTED: It was determined through investigation that all residents had the potential to be affected by the deficient practice. Step #3 TO ENSURE DEFICIENT PRACTICE DOES NOT RECUR: Facility policy regarding abuse was reviewed by members of the IDT. Additional training regarding abuse, prevention, reporting, and chain of command will be completed with ALL staff by the in-service training on Thursday morning, 10am, August 1, 2024. Nurses will receive training specific to their duties and responsibilities by 10am, August 1, 2024. Step #4 MONITORING: If Resident #3 returns to the facility, a staff member will be assigned by the Charge Nurse to conduct one-on-one monitoring of the resident to ensure [Resident #3] is prevented from harming or abusing other residents until final discharge. Step #5 DATE COMPLETED: Removal of the resident from the facility was completed within two and a half hours from receipt of notice of deficient practices to eliminate the immediate threat caused by Resident #3. Policy review and staff training regarding abuse and facility policies and procedures will be completed by 10am, August 1, 2024. On 07/30/24 at 5:04 p.m., the facility was notified the POR was approved. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/01/24 at 3:15 p.m., the Administrator was notified all components of the POR had been. The deficiency remains at an isolated level with a potential for harm. Based on observation, record review, and interview, the facility failed to: a. protect four (#1, #5, #23, and #29) residents from resident to resident abuse, and b. protect six (#10, #17, #18, #23, #24, and #30) sampled residents from sexual abuse. The Administrator identified 28 residents resided in the facility Findings: An Abuse policy, dated 07/2017, reviewed 07/31/24, read in part .the resident has the right to be free from abuse .physical, or sexual .The resident or the resident's representative was involved in the care plan of the behaviors or medical condition to the highest practicable extent . An Abuse Guideline policy, dated 06/2017, read in part Sexual abuse-defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault .Physical abuse-defined as hitting, slapping, pinching, kicking, etc . An Reporting Abuse, Neglect or Mistreatment policy dated 09/2005, read in part .Suspected or substantiated cases of resident abuse .shall be thoroughly investigated and documented by the administrator/designee and reported to the appropriate state agencies .Any alleged violation shall be reported to the administrator (abuse coordinator) or alternate immediately. The administrator shall thoroughly investigate all allegations. The administrator will notify resident's representatives of allegations and investigation. The administrator will take steps to ensure and prevent further potential abuse while the investigation is in process. IF a resident/patient abuses another resident/patient, the resident/patient's physician will be contacted and appropriate action taken to prevent further behavior. If the abusive resident/patient's behavior cannot be controlled, thereby posing a threat of harm to others in the facility, the resident' patient will be discharged . The charge nurse or Director of Nursing will complete an assessment of resident and document findings in the medical record. a. protect four residents from resident to resident abuse 1. Resident #3 had diagnoses which included Dementia, Alzheimer's disease, and intermittent explosive disorder. Resident #3's care plan, dated 05/04/23, read in part The resident is/has potential to be physically aggressive along with sexually invasive and inappropriate Assess and address for contributing sensory deficits .Monitor Q shift Document observed behavior and attempted interventions in behavior log .When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away and approach later . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #3's care plan, dated 05/04/23, read in part The resident has a behavior problem of wandering at night, yelling cursing, hitting staff, hitting dinning [sic] room table with hand yelling we want food before its meal time r/t Dementia .Administer medications as ordered .Anticipate and meet The resident's needs . Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her passing by . Explain all procedures to the resident before starting and allow the resident (x1 minutes) to adjust to changes . A Monthly Summary, dated 05/31/24 at 11:05 p.m., read in part .[Resident #3] continues to be aggressive at times towards staff et other residents, cursing mostly however will get physical et has this last week. Has had a couple altercations in the DR again as well as in the day room especially towards [Res #23] [Resident #3] doubles up their fists et shakes them at [Resident #23] et those are fighting 'word' to this resident et here [Resident #23] will go at [Resident #3] . A Nurses Note, dated 06/30/24 at 3:27 p.m., read in part [Name withheld] in facility, seen [Resident #3]. No new orders received . Resident #3's quarterly assessment, dated 07/10/24, documented Resident #3 had severe cognitive impairment, and physical and verbal behaviors had occurred 1-3 days. 2. Resident #23's quarterly assessment, dated 07/02/24, documented Resident #23 was severely impaired for daily decision making. A progress note, dated 05/29/24 at 7:00 a.m., read in part [Resident #3] coming down the hall this am, when [Resident #3] passed [Resident #23] this [Resident #3] then began hitting [Resident #23] on arm. This nurse began redirecting [Resident #3] at this time .will continue to monitor . There was no documentation all parties had been notified including state agencies, families and the physician regarding Resident #3 and Resident #23's incident. There was no documentation in Resident #23's progress note Resident #23 had been assessed for injuries. 3. Resident #1's quarterly assessment, dated 07/15/24, documented Resident #1 had moderate cognitive impairment. A nurses note, dated 06/04/24 at 3:39 p.m., read in part .While [Resident #1] walking past this resident [Resident #3] began hitting [Resident #1] .When SSD tried redirecting this resident [they] began hitting [SSD]. Resident now in room at time, will continue to monitor . There was no documentation all parties had been notified including state agencies, families and the physician regarding Resident #3 and Resident #1's incident. There was no documentation in Resident #1's progress note Resident #1 had been assessed for injuries. 4. Resident #29's annual assessment, dated 05/21/24, documented Resident #29 had moderate cognitive impairment A nurses note, dated 06/09/24 at 3:24 p.m., read in part .Notified by CMA .that while [Resident #3] in dinning [sic] room [they] began hitting other [Resident #29] at this time. When this nurse asked resident what happened this [Resident #3] stated Resident #3's hitting me. Resident #3 redirected at this time. Will continue to monitor . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no documentation all parties had been notified including state agencies, families and the physician regarding Resident #3 and Resident #29's incident. There was no documentation in Resident #29's progress note Resident #29 had been assessed for injuries. 5. Resident #5's annual assessment, dated 06/03/24, documented Resident #5 had moderate cognitive impairment. A Nurses note, dated 06/26/24 at 9:00 a.m., read in part .While this [Resident #3] was coming down the hallway in wheelchair [they] rolled up to other [Resident #5] at this time. This [Resident #3] then began hitting [Resident #5] in the arm, [Resident #5] began hitting this resident stating Leave me the hell alone you son of a bitch. This nurse and CMA was able to separate residents at this time. Will continue to monitor . There was no documentation all parties had been notified including state agencies, families and the physician regarding Resident #3 and Resident #5's incident. There was no documentation in Resident #5's progress note Resident #5 had been assessed for injuries. A Monthly Summary, dated 6/29/24 at 3:20 a.m., .[Resident #3] continues to be aggressive towards staff et other residents seems [they] have certain residents [they] prefers to approach with [their] aggression i.e. slapping them or hitting them 2 particular residents this last month was [Resident #29] et [Resident #5] . There have been no injuries during these altercations .Resident continues to roam in [their] w/c especially after supper . On 07/29/24 at 10:35 a.m., the DON was asked to review Resident #3's progress notes for resident to resident abuse, dated 05/29/24, 06/04/24, 06/09/24 and 06/26/24 and asked if the Residents had been assessed for injuries, family notified and a state report had been completed. They stated No. b. The following residents were documented in Resident #3's clinical health record as having sexually inappropriate interactions with Resident #3. 1. Resident #3's quarterly assessment, dated 07/10/24, documented Resident #3 had severe cognitive impairment, and physical and verbal behaviors had occurred 1-3 days. Resident #3's care plan, dated 07/08/24, read in part .Resident #3 has sexual behaviors involving other residents .Establish boundaries and limits with Resident .Monitor for emotional factors that may contribute to new behaviors(s) .Provide emotional support regarding new onset disruptive behavior .Reorient resident to person, place, time or situation, Utilize diversion techniques as needed . Resident #3's care plan did not contain any new interventions had been put into place for sexual behaviors after 07/08/24. A Nurses Note, dated 07/11/24 at 12:36 p.m., read in part .[Name of doctor withheld] rounding. [Resident #3] assessed at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #3's Monthly Summary, dated 07/27/24 at 5:19 a.m., read in part .Resident #3 continues to be aggressive toward staff et other residents. Fortunately there have been no injuries during these altercations. Resident #3 continues to roam in [their] w/c especially after supper .Resident #3 during this last 30 days has been aggressive with staff numerous times et has been sexually aggressive to the male residents at least fifteen times that was charted et at times becomes angry at staff for making [them] stop . On 07/28/24 at 8:38 a.m., Resident #3 was observed propelling in their wheelchair in the hallway. 2. Resident #24's significant change assessment, dated 05/30/24, documented Resident #24 had moderate cognitive impairment. A Behavior Note, dated 07/05/24 at 1:05 p.m., read in part .Maintenance and Housekeeping #1 was preparing floors in dining room to buff, and they seen [Resident #3] with [their] hands down the pants of [Resident#24] .They redirected [Resident #3] and moved [Resident #24], and [Resident #3] tried to follow [Resident #24] to [their] room and was redirected again .DON, family notified. Ongoing monitoring . A Behavior Note, dated 07/13/24 at 12:25 p.m., read in part .[Resident #3] went to [Resident #24's] .table and begin trying to feel [them] up. [Resident #3] was asked to go back to [their] table and keep [their] hands to [themselves]. Several other residents in dining room seen [Resident #3] doing this. Sexual behavior is increasing daily. A Behavior Note', dated 07/26/24 at 10:30 a.m., read in part .[Resident #3] constantly touching [Resident #23] another resident inappropriately. [Resident #3] has been talked to and removed from situation. Ongoing monitoring. 3. Resident #17's quarterly assessment, dated 07/10/24, documented Resident #17 had severe cognitive impairment. A Behavior Note, dated 07/06/24 at 7:35 a.m., read in part .[Resident #3] was rubbing on [Resident #17]-another resident's arm, and then came out into hall with [their] pants off. [Resident #3] was taken back to room and dressed .ongoing monitoring. A Nurses Note, dated 07/08/24 at 7:33 a.m., read in part .While this [Resident #3] in front lobby [they] began holding hands with [Resident #17]. While this nurse was trying to redirect [Resident #3], [they] leaned in and kissed [Resident #17]. While this nurse was trying to redirect resident, [they] began hitting this nurse. Will continue to monitor. A Behavior Note, dated 07/13/23 at 5:04 p.m., read in part .Resident [#3] then went to living room and was sitting beside [Resident #17] .and [they] had [their] shirt up with no Bra on, and [they] had [Resident #17's] hand rubbing [their] breast in front of several other residents. [Resident ##3] was told to stop, and not to do that, and [they] continued. This nurse had to go put [Resident #3's] shirt down and get [them] away from [Resident #17] who is in a geri chair and cannot move by [themselves]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 07/21/24 at 11:33 a.m., read in part .[Resident #3] went to [Resident #17]-who is another resident with Alzheimer's and was rubbing [Resident #17's] penis through [their] clothes. We told [Resident #3] again how wrong and inappropriate [their] behaviors and actions are, and[Resident #3] was removed to another room. Sexual behavior is getting worse and more frequent. Ongoing monitoring. 4. Resident #30's, quarterly assessment, dated 05/28/24, documented Resident #30 had severe cognitive impairment. A Behavior Note, dated 07/13/24 at 7:33 a.m., read in part .[Resident #3] is living room, and [they] put [Resident #30's] hand on [their] breast under [their] shirt and was rubbing on [them] inappropriately. [Resident #3] was taken to another room, and [they] was reminded of inappropriate behavior. Ongoing monitoring. A Behavior Note, dated 07/14/24 at 10:50 a.m., read in part .[Resident #3] continues with sexual behaviors. [They] had to be moved away from [Resident #30] another resident 4 times this am, because [they] was rubbing all over {Resident #30]. A Behavior Note, dated 07/18/24 at 9:59 a.m., read in part .[Resident #3] sitting in wheelchair in lobby beside [Resident #30]. [Resident #3] was noted to be rubbing on [Resident #30's] leg by DON .Resident redirected to [their] room . On 07/29/24 at 10:49 a.m., the DON was asked about the incidents involving Resident #30 and Resident #3. They were asked if Resident #30's family had been notified. There was no documentation in Resident #30's progress note the resident's representative had been notified regarding the incidents between resident #30 and Resident #3 on 07/13/24, 07/14/24, and 07/18/24. On 07/29/24 at 11:33 a.m., Resident #30's family member was interviewed via telephone. They were asked if the facility had notified them there had been any altercations with a female resident. They stated No. 5. Resident #18's quarterly assessment, dated 07/01/24, documented Resident #18 had moderate cognitive impairment. A Behavior Note, dated 07/13/23 at 5:04 p.m., .[Resident #3] then headed back to the living room, and [Resident #18] was passing[them] in [their] w/c, and [Resident #3] tried to rub on [Resident #18], and [they] yelled at [Resident #3] to stop, and [Resident #3] quit and went to dining room. A Behavior Note, dated 07/18/24 at 3:23 p.m., read in part .this nurse was notified by [CNA #2] that [Resident #18] notified [CNA#2] [Resident #3] was rubbing on [Resident #18's] leg earlier this shift. DON notified. 6. Resident #23's quarterly assessment, dated 07/02/24, documented Resident #23 was severely impaired for daily decision making. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 07/21/24 at 11:33 a.m., read in part .[Resident #3] has been touching and rubbing on [Resident #23] another resident with Dementia off and on all am. [Resident #3] has been talked to and moved away from other male residents. [Resident #3] has been told how inappropriate it is and as soon as we tell [them] to stop, and get the resident away from [Resident #3] moves onto another male resident. [Resident #3] was just told to leave [Resident #23] alone again, and re-directed, and [Resident #23] was moved to another room . On 07/29/24 at 10:07 a.m., Resident #3 was observed to propel themselves in their wheelchair up to Resident #23 in the common area. Resident #3 was observed to reach toward Resident #23's genital area. No staff were nearby. The IPC nurse was coming out of their office and was alerted to the interaction. The IPC nurse intervened and removed Resident #3 to their room. On 07/29/24 at 10:10 a.m , the IPC nurse was asked to describe what Resident #3 was doing. They stated, [Resident #3] has a tendency to do that, I do not know why [Resident #3] does that touches the men. [Resident #3] was reaching between [Resident #23's] legs trying to fell of [their] private parts They were asked what is being done to protect the male residents. They stated we redirect and take [Resident #3] to their room to watch television. 7. Resident #10's significant change assessment, dated 08/02/24, documented Resident #10 had severe cognitive impairment. A Behavior Note, dated 07/13/23 at 5:04 p.m., read in part .[Resident #3] rubbing on [Resident #10] and Housekeeper #2 told [Resident #3] to stop . On 07/29/24 at 10:35 a.m., the DON was asked what intervention was put into place regarding the inappropriate touching and rubbing for the dates documented above. They stated Resident #3 was redirected, moved to another room, monitored talked to regarding behavior, separated, or told to stop. On 07/29/24 at 10:51 a.m., the DON was asked if they had reported any of the incidents for sexual or resident to resident abuse discussed. They stated No. On 07/29/24 at 11:08 p.m., the DON stated the abuse policy and procedure documented abuse should be reported. On 07/29/24 at 1:51 p.m., the Administrator was asked when the last QA meeting had been held. They stated 07/11/24. They were asked if Resident #3's behaviors had been discussed during the meeting. They stated No. They were asked if resident to resident abuse is reportable. They stated yes, they would notify the family and report the incident. They were asked if the residents involved should be assessed after for injuries. They stated Yes. They were asked if sexual abuse should be reported if the residents involved were not able to consent and touching of genitals would constitute abuse. They stated Yes. They were asked who should complete the state reportable's. They stated they would or the DON.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41872 Based on observation, record review, and interview the facility failed to file incident reports to the state agencies, for a. allegations of physical abuse for four (#1, #5, #23, and #29), b. allegations of sexual abuse for four (#17, #23, #24, and #30), and c. a fall with a major injury for one (#3) of nine sampled residents reviewed for reporting. The Administrator identified 28 residents resided in the facility Findings: An Reporting Abuse, Neglect or Mistreatment policy dated 09/2005, read in part .Suspected or substantiated cases of resident abuse .shall be thoroughly investigated and documented by the administrator/designee and reported to the appropriate state agencies .Any alleged violation shall be reported to the administrator (abuse coordinator) or alternate immediately The administrator will notify resident's representatives of allegations and investigation. The administrator will take steps to ensure and prevent further potential abuse while the investigation is in process. IF a resident/patient abuses another resident/patient, the resident/patient's physician will be contacted and appropriate action taken to prevent further behavior. If the abusive resident/patient's behavior cannot be controlled, thereby posing a threat of harm to others in the facility, the resident' patient will be discharged . The charge nurse or Director of Nursing will complete an assessment of resident and document findings in the medical record. 1. Resident #3's clinical health record contained the following documentation for resident to resident physical abuse interactions with the following residents: Resident #3 had diagnoses which included Dementia, Alzheimer's disease, and intermittent explosive disorder. Resident #3's care plan, dated 05/04/23, read in part The resident is/has potential to be physically aggressive along with sexually invasive and inappropriate Assess and address for contributing sensory deficits .Monitor Q shift Document observed behavior and attempted interventions in behavior log .When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away and approach later . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375571	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilson Nursing Center	867 US Highway 70a Wilson, OK 73463

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3's care plan, dated 05/04/23, read in part The resident has a behavior problem of wandering at night, yelling cursing, hitting staff, hitting dinning [sic] room table with hand yelling we want food before its meal time r/t Dementia .Administer medications as ordered .Anticipate and meet The resident's needs . Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her passing by . Explain all procedures to the resident before starting and allow the resident (x1 minutes) to adjust to changes . A Monthly Summary, dated 05/31/24 at 11:05 p.m., read in part .[Resident #3] continues to be aggressive at times towards staff et other residents, cursing mostly however will get physical et has this last week. Has had a couple altercations in the DR again as well as in the day room especially towards [Res #23] [Resident #3] doubles up their fists et shakes them at [Resident #23] et those are fighting 'word' to this resident et here [Resident #23] will go at [Resident #3] . A Nurses Note, dated 06/30/24 at 3:27 p.m., read in part [Name withheld] in facility, seen [Resident #3]. No new orders received . Resident #3's quarterly assessment, dated 07/10/24, documented Resident #3 had severe cognitive impairment, and physical and verbal behaviors had occurred 1-3 days. 2. Resident #23's quarterly assessment, dated 07/02/24, documented Resident #23 was severely impaired for daily decision making. A progress note, dated 05/29/24 at 7:00 a.m., read in part [Resident #3] coming down the hall this am, when [Resident #3] passed [Resident #23] this [Resident #3] then began hitting [Resident #23] on arm. This nurse began redirecting [Resident #3] at this time .will continue to monitor . There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #23's incident. 3. Resident #1's quarterly assessment, dated 07/15/24, documented Resident #1 had moderate cognitive impairment. A nurses note, dated 06/04/24 at 3:39 p.m., read in part .While [Resident #1] walking past this resident [Resident #3] began hitting [Resident #1] .When SSD tried redirecting this resident [they] began hitting [SSD]. Resident now in room at time, will continue to monitor . There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #1's incident. 4. Resident #29's annual assessment, dated 05/21/24, documented Resident #29 had moderate cognitive impairment A nurses note, dated 06/09/24 at 3:24 p.m., read in part .Notified by CMA .that while [Resident #3] in dinning [sic] room [they] began hitting other [Resident #29] at this time. When this nurse asked resident what happened this [Resident #3] stated She's hitting me. This resident redirected at this time. Will continue to monitor . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #29's incident. 5. Resident #5's annual assessment, dated 06/03/24, documented Resident #5 had moderate cognitive impairment. A Nurses note, dated 06/26/24 at 9:00 a.m., read in part .While this [Resident #3] was coming down the hallway in wheelchair [they] rolled up to other [Resident #5] at this time. This [Resident #3] then began hitting [Resident #5] in the arm, [Resident #5] began hitting this resident stating Leave me the hell alone you son of a bitch. This nurse and CMA was able to separate residents at this time. Will continue to monitor . There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #5's incident. A Monthly Summary, dated 6/29/24 at 3:20 a.m., .[Resident #3] continues to be aggressive towards staff et other residents seems [they] have certain residents [they] prefers to approach with [their] aggression i.e. slapping them or hitting them 2 particular residents this last month was [Resident #29] et [Resident #5] . There have been no injuries during these altercations .Resident continues to roam in [their] w/c especially after supper . On 07/29/24 at 10:35 a.m., the DON was asked to review Resident #3's progress notes for resident to resident abuse, dated 05/29/24, 06/04/24, 06/09/24 and 06/26/24 and asked if the Residents had been assessed for injuries, family notified and a state report had been completed. They stated No. b. The following residents was documented in Resident #3's clinical health record as having sexually inappropriate interactions with Resident #3. 1. Resident #3's quarterly assessment, dated 07/10/24, documented Resident #3 had severe cognitive impairment, and physical and verbal behaviors had occurred 1-3 days. Resident #3's care plan, dated 07/08/24, read in part .Resident has sexual behaviors involving other residents .Establish boundaries and limits with Resident .Monitor for emotional factors that may contribute to new behaviors(s) .Provide emotional support regarding new onset disruptive behavior .Reorient resident to person, place, time or situation, Utilize diversion techniques as needed . Resident #3's care plan did not contain any new interventions had been put into place for sexual behaviors after 07/08/24. A Nurses Note, dated 07/11/24 at 12:36 p.m., read in part .[Name of doctor withheld] rounding. [Resident #3] assessed at this time. Resident #3's Monthly Summary, dated 07/27/24 at 5:19 a.m., read in part .Resident continues to be aggressive toward staff et other residents. Fortunately there have been no injuries during these altercations. Resident continues to roam in [their] w/c especially after supper .Resident during this last 30 days has been aggressive with staff numerous times et has been sexually aggressive to the male residents at least fifteen times that was charted et at times becomes angry at staff for making [them] stop . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/28/24 at 8:38 a.m., Resident #3 was observed propelling in their wheelchair in the hallway. 2. Resident #24's significant change assessment, dated 05/30/24, documented Resident #24 had moderate cognitive impairment. A Behavior Note, dated 07/05/24 at 1:05 p.m., read in part .Maintenance and Housekeeping #1 was preparing floors in dining room to buff, and they seen [Resident #3] with [their] hands down the pants of [Resident#24] .They redirected [Resident #3] and moved [Resident #24], and [Resident #3] tried to follow [Resident #24] to [their] room and was redirected again .DON, family notified. Ongoing monitoring . A Behavior Note, dated 07/13/24 at 12:25 p.m., read in part .[Resident #3] went to [Resident #24's] .table and begin trying to feel [them] up. [Resident #3] was asked to go back to [their] table and keep [their] hands to [themselves]. Several other residents in dining room seen [Resident #3] doing this. Sexual behavior is increasing daily. A Behavior Note', dated 07/26/24 at 10:30 a.m., read in part .[Resident #3] constantly touching [Resident #23] another resident inappropriately. [Resident #3] has been talked to and removed from situation. Ongoing monitoring. 3. Resident #17's quarterly assessment, dated 07/10/24, documented Resident #17 had severe cognitive impairment. A Behavior Note, dated 07/06/24 at 7:35 a.m., read in part .[Resident #3] was rubbing on [Resident #17]-another resident's arm, and then came out into hall with [their] pants off. [Resident #3] was taken back to room and dressed .ongoing monitoring. A Nurses Note, dated 07/08/24 at 7:33 a.m., read in part .While this [Resident #3] in front lobby [they] began holding hands with [Resident #17]. While this nurse was trying to redirect [Resident #3], [they] leaned in and kissed [Resident #17]. While this nurse was trying to redirect resident, [they] began hitting this nurse. Will continue to monitor. A Behavior Note, dated 07/13/23 at 5:04 p.m., read in part .Resident [#3] then went to living room and was sitting beside [Resident #17] .and [they] had [their] shirt up with no Bra on, and [they] had [Resident #17's] hand rubbing [their] breast in front of several other residents. [Resident ##3] was told to stop, and not to do that, and [they] continued. This nurse had to go put [Resident #3's] shirt down and get [them] away from [Resident #17] who is in a geri chair and cannot move by [themselves]. A Behavior Note, dated 07/21/24 at 11:33 a.m., read in part .[Resident #3] went to [Resident #17]-who is another resident with Alzheimer's and was rubbing [Resident #17's] penis through [their] clothes. We told [Resident #3] again how wrong and inappropriate [their] behaviors and actions are, and[Resident #3] was removed to another room. Sexual behavior is getting worse and more frequent. Ongoing monitoring. 4. Resident #30's, quarterly assessment, dated 05/28/24, documented Resident #30 had severe cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Behavior Note, dated 07/13/24 at 7:33 a.m., read in part .[Resident #3] is living room, and [they] put [Resident #30's] hand on [their] breast under [their] shirt and was rubbing on [them] inappropriately. [Resident #3] was taken to another room, and [they] was reminded of inappropriate behavior. Ongoing monitoring. A Behavior Note, dated 07/14/24 at 10:50 a.m., read in part .[Resident #3]continues with sexual behaviors. [They] had to be moved away from [Resident #30] another resident 4 times this am, because [they] was rubbing all over {Resident #30]. A Behavior Note, dated 07/18/24 at 9:59 a.m., read in part .[Resident #3] sitting in wheelchair in lobby beside [Resident #30]. [Resident #3] was noted to be rubbing on [Resident #30's] leg by DON .Resident redirected to [their] room . On 07/29/24 at 10:49 a.m., the DON was asked about the incidents involving Resident #30 and Resident #3. They were asked if Resident #30's family had been notified. There was no documentation in Resident #30's progress note the resident's representative had been notified regarding the incidents between Resident #30 and Resident #3 on 07/13/24, 07/14/24, and 07/18/24. On 07/29/24 at 11:33 a.m., Resident #30's family member was interviewed via telephone. They were asked if the facility had notified them there had been any altercations with a female resident. They stated No. 5. Resident #23's quarterly assessment, dated 07/02/24, documented Resident #23 was severely impaired for daily decision making. A Behavior Note, dated 07/21/24 at 11:33 a.m., read in part .[Resident #3] has been touching and rubbing on [Resident #23] another resident with Dementia off and on all am. [Resident #3] has been talked to and moved away from other male residents. [Resident #3] has been told how inappropriate it is and as soon as we tell [them] to stop, and get the resident away from [Resident #3] moves onto another male resident. [Resident #3] was just told to leave [Resident #23] alone again, and re-directed, and [Resident #23] was moved to another room . On 07/29/24 at 10:07 a.m., Resident #3 was observed to propel themselves in their wheelchair up to Resident #23 in the common area. Resident #3 was observed to reach toward Resident #23's genital area. No staff were nearby. The IPC nurse was coming out of their office and was alerted to the interaction. The IPC nurse intervened and removed Resident #3 to their room. On 07/29/24 at 10:10 a.m , the IPC nurse was asked to describe what Resident #3 was doing. They stated, [Resident #3] has a tendency to do that, I do not know why [Resident #3] does that touches the men. [Resident #3] was reaching between [Resident #23's] legs trying to fell of [their] private parts They were asked what is being done to protect the male residents. They stated we redirect and take [Resident #3] to their room to watch television. On 07/29/24 at 10:51 a.m., the DON was asked if they had reported any of the incidents for sexual or resident to resident abuse discussed. They stated No. On 07/29/24 at 11:08 p.m., the DON stated the abuse policy and procedure documented abuse should be reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 07/31/24 at 3:03 p.m., Resident #3's [family member] stated they were never told what the reason was when Resident #3 had fallen which resulted in a fracture. They were now aware there was an incident involving another resident on 05/01/24. They were asked if they had been notified regarding Resident #3's physical and sexual behaviors. They stated they were aware of incidents in the past but had not been notified of any behaviors since [Resident #3] fell on [DATE]. On 07/31/24 at 4:07 p.m., LPN #1 was asked to describe the incident with Resident #23 and Resident #3 on 05/01/24. They stated the residents passed by each other and Resident #3 had stated they were trying to get away from Resident #23 and fell by the director of operations office. On 07/31/24 at 4:20 p.m., the DON was asked if they had had filed a state report when Resident #3 had fallen and had a fractured pelvis. They stated they thought they had but would have to look. The book with incident reports was reviewed and did not contain a report had been sent to the OSDH. The facility did not provide any documentation a state report had been sent for Resident #3's fall on 05/01/24. On 07/29/24 at 1:51 p.m., the Administrator was asked when the last QA meeting had been held. They stated 07/11/24. They were asked if Resident #3's behaviors had been discussed during the meeting. They stated No. They were asked if resident to resident abuse is reportable. They stated yes, they would notify the family and report the incident. They stated Yes. They were asked if sexual abuse should be reported if the residents involved were not able to consent and touching of genitals would constitute abuse. They stated Yes. They were asked who should complete the state reports. They stated they would or the DON.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 41872 Based on observation, record review, and interview the facility failed to investigate allegations of resident to resident abuse for four (#1, #5, #23, and #29) and investigate allegations of sexual abuse for four (#17, #23, #24, and #30) eight sampled residents for abuse. The Administrator identified 28 residents resided in the facility Findings: An Reporting Abuse, Neglect or Mistreatment policy dated 09/2005, read in part .Suspected or substantiated cases of resident abuse .shall be thoroughly investigated and documented by the administrator/designee and reported to the appropriate state agencies .Any alleged violation shall be reported to the administrator (abuse coordinator) or alternate immediately The administrator will notify resident's representatives of allegations and investigation. The administrator will take steps to ensure and prevent further potential abuse while the investigation is in process. IF a resident/patient abuses another resident/patient, the resident/patient's physician will be contacted and appropriate action taken to prevent further behavior. If the abusive resident/patient's behavior cannot be controlled, thereby posing a threat of harm to others in the facility, the resident' patient will be discharged . The charge nurse or Director of Nursing will complete an assessment of resident and document findings in the medical record. 1. Resident #3's clinical health record contained the following documentation for resident to resident physical abuse interactions with the following residents: Resident #3 had diagnoses which included Dementia, Alzheimer's disease, and intermittent explosive disorder. Resident #3's care plan, dated 05/04/23, read in part The resident is/has potential to be physically aggressive along with sexually invasive and inappropriate Assess and address for contributing sensory deficits .Monitor Q shift Document observed behavior and attempted interventions in behavior log .When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away and approach later . Resident #3's care plan, dated 05/04/23, read in part The resident has a behavior problem of wandering at night, yelling cursing, hitting staff, hitting dinning [sic] room table with hand yelling we want food before its meal time r/t Dementia .Administer medications as ordered .Anticipate and meet The resident's needs . Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her passing by . Explain all procedures to the resident before starting and allow the resident (x1 minutes) to adjust to changes . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Monthly Summary, dated 05/31/24 at 11:05 p.m., read in part .[Resident #3] continues to be aggressive at times towards staff et other residents, cursing mostly however will get physical et has this last week. Has had a couple altercations in the DR again as well as in the day room especially towards [Res #23] [Resident #3] doubles up their fists et shakes them at [Resident #23] et those are fighting 'word' to this resident et here [Resident #23] will go at [Resident #3] . A Nurses Note, dated 06/30/24 at 3:27 p.m., read in part [Name withheld] in facility, seen [Resident #3]. No new orders received . Resident #3's quarterly assessment, dated 07/10/24, documented Resident #3 had severe cognitive impairment, and physical and verbal behaviors had occurred 1-3 days. 2. Resident #23's quarterly assessment, dated 07/02/24, documented Resident #23 was severely impaired for daily decision making. A progress note, dated 05/29/24 at 7:00 a.m., read in part [Resident #3] coming down the hall this am, when [Resident #3] passed [Resident #23] this [Resident #3] then began hitting [Resident #23] on arm. This nurse began redirecting [Resident #3] at this time .will continue to monitor . There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #23's incident. 3. Resident #1's quarterly assessment, dated 07/15/24, documented Resident #1 had moderate cognitive impairment. A nurses note, dated 06/04/24 at 3:39 p.m., read in part .While [Resident #1] walking past this resident [Resident #3] began hitting [Resident #1] .When SSD tried redirecting this resident [they] began hitting [SSD]. Resident now in room at time, will continue to monitor . There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #1's incident. 4. Resident #29's annual assessment, dated 05/21/24, documented Resident #29 had moderate cognitive impairment A nurses note, dated 06/09/24 at 3:24 p.m., read in part .Notified by CMA .that while [Resident #3] in dinning [sic] room [they] began hitting other [Resident #29] at this time. When this nurse asked resident what happened this [Resident #3] stated She's hitting me. This resident redirected at this time. Will continue to monitor . There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #29's incident. 5. Resident #5's annual assessment, dated 06/03/24, documented Resident #5 had moderate cognitive impairment. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nurses note, dated 06/26/24 at 9:00 a.m., read in part .While this [Resident #3] was coming down the hallway in wheelchair [they] rolled up to other [Resident #5] at this time. This [Resident #3] then began hitting [Resident #5] in the arm, [Resident #5] began hitting this resident stating Leave me the hell alone you son of a bitch. This nurse and CMA was able to separate residents at this time. Will continue to monitor . There was no documentation an incident report had been filed and all state agencies had been notified regarding Resident #3 and Resident #5's incident. A Monthly Summary, dated 6/29/24 at 3:20 a.m., .[Resident #3] continues to be aggressive towards staff et other residents seems [they] have certain residents [they] prefers to approach with [their] aggression i.e. slapping them or hitting them 2 particular residents this last month was [Resident #29] et [Resident #5] . There have been no injuries during these altercations .Resident continues to roam in [their] w/c especially after supper . On 07/29/24 at 10:35 a.m., the DON was asked to review Resident #3's progress notes for resident to resident abuse, dated 05/29/24, 06/04/24, 06/09/24 and 06/26/24 and asked if the Residents had been assessed for injuries, family notified and a state report had been completed. They stated No. b. The following residents was documented in Resident #3's clinical health record as having sexually inappropriate interactions with Resident #3. 1. Resident #3's quarterly assessment, dated 07/10/24, documented Resident #3 had severe cognitive impairment, and physical and verbal behaviors had occurred 1-3 days. Resident #3's care plan, dated 07/08/24, read in part .Resident has sexual behaviors involving other residents .Establish boundaries and limits with Resident .Monitor for emotional factors that may contribute to new behaviors(s) .Provide emotional support regarding new onset disruptive behavior .Reorient resident to person, place, time or situation, Utilize diversion techniques as needed . Resident #3's care plan did not contain any new interventions had been put into place for sexual behaviors after 07/08/24. A Nurses Note, dated 07/11/24 at 12:36 p.m., read in part .[Name of doctor withheld] rounding. [Resident #3] assessed at this time. Resident #3's Monthly Summary, dated 07/27/24 at 5:19 a.m., read in part .Resident continues to be aggressive toward staff et other residents. Fortunately there have been no injuries during these altercations. Resident continues to roam in [their] w/c especially after supper .Resident during this last 30 days has been aggressive with staff numerous times et has been sexually aggressive to the male residents at least fifteen times that was charted et at times becomes angry at staff for making [them] stop . On 07/28/24 at 8:38 a.m., Resident #3 was observed propelling in their wheelchair in the hallway. 2. Resident #24's significant change assessment, dated 05/30/24, documented Resident #24 had moderate cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Behavior Note, dated 07/05/24 at 1:05 p.m., read in part .Maintenance and Housekeeping #1 was preparing floors in dining room to buff, and they seen [Resident #3] with [their] hands down the pants of [Resident#24] .They redirected [Resident #3] and moved [Resident #24], and [Resident #3] tried to follow [Resident #24] to [their] room and was redirected again .DON, family notified. Ongoing monitoring . A Behavior Note, dated 07/13/24 at 12:25 p.m., read in part .[Resident #3] went to [Resident #24's] .table and begin trying to feel [them] up. [Resident #3] was asked to go back to [their] table and keep [their] hands to [themselves]. Several other residents in dining room seen [Resident #3] doing this. Sexual behavior is increasing daily. A Behavior Note', dated 07/26/24 at 10:30 a.m., read in part .[Resident #3] constantly touching [Resident #23] another resident inappropriately. [Resident #3] has been talked to and removed from situation. Ongoing monitoring. 3. Resident #17's quarterly assessment, dated 07/10/24, documented Resident #17 had severe cognitive impairment. A Behavior Note, dated 07/06/24 at 7:35 a.m., read in part .[Resident #3] was rubbing on [Resident #17]-another resident's arm, and then came out into hall with [their] pants off. [Resident #3] was taken back to room and dressed .ongoing monitoring. A Nurses Note, dated 07/08/24 at 7:33 a.m., read in part .While this [Resident #3] in front lobby [they] began holding hands with [Resident #17]. While this nurse was trying to redirect [Resident #3], [they] leaned in and kissed [Resident #17]. While this nurse was trying to redirect resident, [they] began hitting this nurse. Will continue to monitor. A Behavior Note, dated 07/13/23 at 5:04 p.m., read in part .Resident [#3] then went to living room and was sitting beside [Resident #17] .and [they] had [their] shirt up with no Bra on, and [they] had [Resident #17's] hand rubbing [their] breast in front of several other residents. [Resident ##3] was told to stop, and not to do that, and [they] continued. This nurse had to go put [Resident #3's] shirt down and get [them] away from [Resident #17] who is in a geri chair and cannot move by [themselves]. A Behavior Note, dated 07/21/24 at 11:33 a.m., read in part .[Resident #3] went to [Resident #17]-who is another resident with Alzheimer's and was rubbing [Resident #17's] penis through [their] clothes. We told [Resident #3] again how wrong and inappropriate [their] behaviors and actions are, and[Resident #3] was removed to another room. Sexual behavior is getting worse and more frequent. Ongoing monitoring. 4. Resident #30's, quarterly assessment, dated 05/28/24, documented Resident #30 had severe cognitive impairment. A Behavior Note, dated 07/13/24 at 7:33 a.m., read in part .[Resident #3] is living room, and [they] put [Resident #30's] hand on [their] breast under [their] shirt and was rubbing on [them] inappropriately. [Resident #3] was taken to another room, and [they] was reminded of inappropriate behavior. Ongoing monitoring. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilson Nursing Center	867 US Highway 70a Wilson, OK 73463

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Behavior Note, dated 07/14/24 at 10:50 a.m., read in part .[Resident #3]continues with sexual behaviors. [They] had to be moved away from [Resident #30] another resident 4 times this am, because [they] was rubbing all over [Resident #30]. A Behavior Note, dated 07/18/24 at 9:59 a.m., read in part .[Resident #3] sitting in wheelchair in lobby beside [Resident #30]. [Resident #3] was noted to be rubbing on [Resident #30's] leg by DON .Resident redirected to [their] room . On 07/29/24 at 10:49 a.m., the DON was asked about the incidents involving Resident #30 and Resident #3. They were asked if Resident #30's family had been notified. There was no documentation in Resident #30's progress note the resident's representative had been notified regarding the incidents between Resident #30 and Resident #3 on 07/13/24, 07/14/24, and 07/18/24. On 07/29/24 at 11:33 a.m., Resident #30's family member was interviewed via telephone. They were asked if the facility had notified them there had been any altercations with a female resident. They stated No. 5. Resident #23's quarterly assessment, dated 07/02/24, documented Resident #23 was severely impaired for daily decision making. A Behavior Note, dated 07/21/24 at 11:33 a.m., read in part .[Resident #3] has been touching and rubbing on [Resident #23] another resident with Dementia off and on all am. [Resident #3] has been talked to and moved away from other male residents. [Resident #3] has been told how inappropriate it is and as soon as we tell [them] to stop, and get the resident away from [Resident #3] moves onto another male resident. [Resident #3] was just told to leave [Resident #23] alone again, and re-directed, and [Resident #23] was moved to another room . On 07/29/24 at 10:07 a.m., Resident #3 was observed to propel themselves in their wheelchair up to Resident #23 in the common area. Resident #3 was observed to reach toward Resident #23's genital area. No staff were nearby. The IPC nurse was coming out of their office and was alerted to the interaction. The IPC nurse intervened and removed Resident #3 to their room. On 07/29/24 at 10:10 a.m , the IPC nurse was asked to describe what Resident #3 was doing. They stated, [Resident #3] has a tendency to do that, I do not know why [Resident #3] does that touches the men. [Resident #3] was reaching between [Resident #23's] legs trying to fell of [their] private parts They were asked what is being done to protect the male residents. They stated we redirect and take [Resident #3] to their room to watch television. On 07/29/24 at 10:51 a.m., the DON was asked if they had reported any of the incidents for sexual or resident to resident abuse discussed. They stated No. On 07/29/24 at 11:08 p.m., the DON stated the abuse policy and procedure documented abuse should be reported. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/29/24 at 1:51 p.m., the Administrator was asked when the last QA meeting had been held. They stated 07/11/24. They were asked if Resident #3's behaviors had been discussed during the meeting. They stated No. They were asked if resident to resident abuse is reportable. They stated yes, they would notify the family and report the incident. They stated Yes. They were asked if sexual abuse should be reported if the residents involved were not able to consent and touching of genitals would constitute abuse. They stated Yes. They were asked who should complete the state reports. They stated they would or the DON.

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. 46653 Based on record review and interview, the failed to ensure coordination of resident assessment and death record for one (#7) of one sampled resident who were reviewed for assessments. The DON reported 28 residents resided in the facility. Findings: Residnet # 7 had a diagnosis of Congestive Heart Failure. On 08/01/24 at 8:30 a.m., there was no record or documentation for Resident #7 death record or resident assessment. On 07/31/24 at 4:17 a.m. , the DON reported there was no death record or resident assessment for Resident #7.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41872 Based on record review and interview, the facility failed to update the care plan to reflect Hospice services were in place for one (#17)of two sampled residents who received hospice services. The Administrator identified 28 residents resided in the facility. LPN #1 identified five residents recieved hospice services. Findings: Resident #17 had diagnoses which included heart disease, type two diabetes mellitus and acute kidney failure. A hospice progress report documented Resident #17 was admitted to Hospice services on 01/03/24. Resident #17's care plan did not document Resident #17 was receiving Hospice Services. On 08/05/24 at 11:14 a.m., LPN #1 was asked if the residents care plan documented [they] were receiving hospice services. LPN #1 reviewed the care plan and stated I don't see one.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41872 On 07/31/24 at 4:52 p.m., the OSDH identified the presence of an immediate jeopardy related to wound care. Resident #10 developed an unstageable pressure ulcer to their right hip. The facility failed to ensure wound care orders were obtained and implemented in a timely manner to prevent worsening of the wound. On 07/31/24 at 5:02 p.m., the Administrator, DON, and Director of Operations were notified of the immediate jeopardy related to wound care. The facility was asked to submit a plan of removal. On 08/01/24 at 1:46 p.m., the facility submitted a plan of removal to the Oklahoma State Department of Health. The following is the plan of removal: Step #1 CORRECTIVE ACTIONS: Upon notification of the deficient practice, immediate action was taken to protect residents at risk of serious injury, harm, impairment or death. Within the hour of notification of the deficient practice, orders were obtained for the appropriate wound care. All nursing staff, including hospice personnel were immediately notified of the deficient practice and educated on the importance of timely, and effective communication. [NAME] Nursing Center staff was educated on obtaining orders from facility Medical Director in the event of not being able to obtain time sensitive orders from a hospice medical director. Baseline skin assessment completed and documented on all residents residing in the facility. Step #2 IDENTIFICATION OF OTHERS WITH THE POTENTIAL OF BEING AFFECTED: It was determined through investigation that all residents had the potential to be affected by the deficient practice. Step #3 TO ENSURE DEFICIENT PRACTICE DOES NOT RECUR: Facility policy regarding wound care was reviewed by members of the IDT on 07/31/2024. [NAME] Nursing Center will perform weekly skin assessments on all residents and document in skin assessments as well as in narrative format. Any resident with a known wound will have photo documentation weekly under the miscellaneous tab in the EHR. Additional training regarding skin integrity, wound prevention, reporting, and chain of command will be completed with ALL staff by the in-service training on Thursday morning, 11am, August 1, 2024. Step #4 MONITORING: The Director of Nurses will perform weekly chart audits and QA all orders and notes on every patient. The Director of Nurses will delegate weekly chart audits to a registered nurse to assist in accurate and timely documentation. Residents having an area of concern or wound will be assessed and documented daily. The Director of Nurses will ensure this by reviewing not only the EHR but assisting in wound care. Resident care plans will be immediately updated to reflect the area of concern with skin integrity. Results of the audits will be reviewed by the QA Committee. Step #5 DATE COMPLETED: Orders were immediately received upon notification of the deficient practice. [NAME] Nursing Center will educate and in-service all ancillary staff, to include hospice providers on orders being received and in place within the day of notification. This in-servicing will be completed by 11am on 08/01/2024. Policy review and staff training regarding wound care and facility policies and procedures will be completed by August 1, 2024. On 08/01/24 at 3:09 p.m., the facility was notified the POR was accepted. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/05/24 at 1:46 p.m., all components of the plan of removal was reviewed and completed. On 08/05/24 at 2:22 p.m., the facility was notified the immediacy had been lifted. The deficiency remains at an isolated level with a potential for harm. Based on observation, record review, and interview, the facility failed to ensure wound care orders were obtained in a timely manner to prevent worsening of a wound for two (#10 and #17) of two sampled residents reviewed for wounds. The Administrator identified 28 residents who resided in the facility. Findings: A Treatment Guidelines for Pressure Sores Stage I policy, dated 07/2005, read in part, .Confirm the resident and interested party of the resident has been notified of the pressure sore and is aware of the current status. Document in the progress notes .Document dressing completion on the treatment administration record . Complete Weekly Skin Condition Report-Pressure form weekly until sore is resolved . A Treatment Guidelines for Pressure Sores Stage II policy, dated 07/2005, read in part .to promote re-epithelialization and prevent further deterioration of wound .Confirm the physician has been notified that the resident has a pressure sore and aware of the current status. Document in the progress notes . Document care and appearance of skin, dressing as indicated on the Daily Wound Assessment form. Indicate dressing change date, time and initials on the dressing. Document dressing completion on the treatment administration record .Complete Weekly Skin Condition Report-Pressure form weekly until sore is resolved . A Treatment Guidelines for Pressure Sores Stage III policy, dated 07/2005, read in part .to promote healing of the wound and prevent further deterioration of wound .Confirm the physician has been notified that the resident has a pressure sore and aware of the current status. Document in the progress notes .Document care and appearance of skin, dressing as indicated on the Daily Wound Assessment form. Indicate dressing change date, time and initials on the dressing. Document dressing completion on the treatment administration record .Complete Weekly Skin Condition Report-Pressure form weekly until sore is resolved . A Treatment Guidelines for Pressure Sores Stage IV policy, dated 07/2005, read in part .To promote healing of the wound (granulation, contraction, epithelization0 and prevent further deterioration of wound .Confirm the physician has been notified that the resident has a pressure sore and aware of the current status. Document in the progress notes .Document care and appearance of skin, dressing as indicated on the Daily Wound Assessment form. Indicate dressing change date, time and initials on the dressing. Document dressing completion on the treatment administration record .Complete Weekly Skin Condition Report-Pressure form weekly until sore is resolved . 1. Resident #10 had diagnoses which included traumatic brain injury, type two diabetes mellitus, dementia, and muscle weakness. A Nurse Note, dated 05/20/24 at 5:48 p.m., documented the resident had a visible half dollar carpet like abrasion to right out knee cap and right temple. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Braden Scale For Predicting Pressure sore Risk, dated 05/22/24, documented Resident #10 was at risk. Resident #10's Treatment Administration Record dated 06/01/24 through 06/28/24, read in part Cleanse area per facility protocol, pat dry, apply TAO and cover with dressing daily, one time a day for Open area Order date 05/29/24 .D/C date 06/29/24 . The TAR had staff initials the task had been completed every day for the month of June until 06/30/24. The order did not specify what area was to be cleansed, and dressed. A Nurse Note, dated 06/15/24 at 10:38 a.m., read in part Resident's rt hip is discolored. Resident also has a raised rash that looks like a heat rash to rt hip . A Nurse Note, dated 06/20/24 at 5:29 p.m., documented Resident #10 was galded in their peri area and had a rash on their back that was worsening. A Nurse Note dated 06/27/24 at 4:42 a.m., read in part .Resident noted to have a stage 1 pressure sore on right hip 1.5 x 1.0 covered with foam dressing .Will pass on to oncoming nurse . A Physician Order, dated 06/29/24, read in part Cleanse area per facility protocol, pat dry, apply TAO and cover with dressing daily. every 12 hours as needed for open area The order did not specify what area was to be treated. A Monthly Summary, dated 06/29/24 at 1:53 a.m., read in part .under the care of [name of Hospice] .refuses to let staff change [their] brief most of the time .Has developed a Stg 1 to Rt hip with daily drsg's applied . Resident #10's TAR dated 07/01/24 through 07/29/24 did not contain documentation the physician order for prn TAO dressing changes had been, dated 06/29/24, had been implemented. A Hospice note, dated 07/10/24 at 8:55 a.m., documented Resident #10's integumentary as bruised, pale and poor turgor. It did not address any wounds or wound care was provided. A Skin/Wound Note, dated 07/12/24 at 4:03 p.m., read in part .Resident has a stage 2 SDTI to rt hip 5x7x0. 1cm. [Name of Hospice withheld] ,and [family member] aware, and will notify .DON. Protective barrier cream applied . A 'Skin/Wound Note, dated 07/14/24 at 5:09 p.m., read in part, [Name of Hospice withheld] have not got back to facility on wound care orders for resident .DON will contact them Monday. Barrier cream, and t&RQ2h .SDTI to rt hip is starting to drain on brief. Covered with non-stick telfa pad for now . A Nurse Note, dated 07/16/24 at 1:34 a.m., read in part .Resident remains non compliant and refuses to allow nursing to do anything .including wound care. Area to bilateral hips have been open and closing since [they] was admitted . Resident has an unstageable pressure are worsening to right hip. This RN discussed with RN Director of Nursing and will be sending wound care team out to evaluate and attempt to let resident allow staff to treat . There was no documentation from 07/16/24 through 07/21/24 Resident #10 had refused wound care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospice Visit Note Report, dated 07/17/24 at 6:07 p.m., read in part .Patient has an unstageable pressure injury to right hip (5x4.5x0.4) and patient has a deep pressure injury to right heel (3x3.5x0). Both cleanse and covered with optifoam .The facility was advised to do wet to dry on the hip daily and off load pressure to right heel . A hospice Physician Order, dated 07/17/24 at 6:07 p.m., read in part SN/Facility to cleanse right hip with normal saline pat dry, apply a wet to dry secure dressing, secure with tape daily/prn . A Skin/Wound Note, dated 07/21/24 at 3:33 p.m., read in part Resident has a SDTI to rt hip 8x8.4x0.1cm edges area open with 90%% yellow slough hard tissue, 10% brown eschar, with red peri-wound skin. Rt buttocks 5x2.7x0.1cm open area where tip layer skin sloughed off. Rt. Posterior heel had area 5.5 x 5cm area possible blister with purulent drainage coming out of it .Rt lateral heel has SDTI/blood blister 3x3.4cm . [Name of Hospice withheld] called to have them come out and look at wounds and give us wound care orders. They will have someone come out tomorrow. Protective cream applied, and wounds temporarily covered with large band aide/DRSG for protection . A Nurses Note, dated 07/22/24 at 3:00 p.m., read in part Late Entry .[Hospice RN] in facility at this time to see the resident. This nurse informed RN that wound care specialist was to be visiting resident to evaluate wound and give orders, but no one had come at this time. [Hospice RN] unable to explain why wound care had not shown up .[Hospice RN] was to call facility back with information concerning wound care. A Nurse Note, dated 07/24/24 at 4:01 p.m., read in part .While doing wound care on resident this nurse noticed DTI on Left heel at this time . A Monthly Summary, dated 07/27/24 at 3:58 a.m., read in part .refuses to let staff change [their] brief a lot of the time resulting in [them] having significant skin breakdown to [their] Rt hip .[Name of Hospice] had been notified of residents skin issues however have yet to assess the situation et leaving us with no wound orders. A Skin/Wound Note, dated 07/27/24 at 4:00 p.m., read in part, .Wound care provided to resident's left[error] hip SDTI unstageable (9.6x8x0.1cm) with red periwound skin, 95% tan eschar 5% yellow slough around outer edge with x-large amount of purulent malodorous drainage. [Name of Hospice] is aware .Topical TAO applied to peri-wound skin . The Resident Matrix, dated 07/28/24, read in part .Pressure Ulcer(s) .not present on admission did not identify any residents with wounds. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/30/24 at 2:20 p.m., LPN #1 provided a copy of wound care orders that was faxed to the facility on [DATE] from Hospice. They were asked what was in place for Resident #10's wound care. They stated Resident #10 is non-compliant and refuses wound care a lot. They were asked what was in place for prevention. They stated to turn and reposition and float their heels with a pillow. LPN #1 was asked why had they not gotten orders on 07/14/24 when there was no return from Hospice. They stated I don't know, They were asked what was done when the wound was draining. They stated the wound was covered with Telfa. They stated a wound care team was supposed to come out but did not show so no orders were given. They were asked why hadn't the facility started wound care. They stated. We failed to get wound care orders, we should have went around hospice and got orders from [facility doctor]. LPN #1 was asked what a prudent nurse should have done in that situation. They stated, We should have been more diligent to get orders from the primary care provider to provide the best care for the resident. On 07/30/24 at 3:33 p.m., the DON was asked to about Resident #10's wounds. They stated Resident #10 would only allow them to use TAO, telfa and tape. They stated they had reached out to hospice. They came out and the Resident refused so we continued with that treatment. The DON stated they had talked to hospice and they were supposed to send someone out on 07/22/24. The DON stated they reached out to Hospice and got an order today from Hospice. They stated they had reached out to the [facility physician] to get orders. The DON was shown the June 2024 TAR and asked if they had only used TAO, telfa and tape for wound care for the month of June and July. They stated they had gotten orders today (07/30/24). On 07/30/24 at 4:10 p.m., LPN #1 was asked who gave the order on June 29th to change to PRN treatment. They stated they got a verbal order from the hospice nurse to change to prn since the resident refused. On 07/31/24 at 10:49 a.m., LPN #1 was asked if they were aware of the hospice wound care orders, dated 07/17/24. They stated they were not aware and had not been implemented. On 07/31/24 at 11:28 a.m., the DON stated Hospice was in the building on 07/17/24 on night shift to assess the resident for wound care. On 07/31/24 at 11:41 a.m., the DON was asked why the orders for the wound care (dated 07/17/24) had not been implemented. They stated they had just received the orders yesterday. On 08/01/24 at 8:28 a.m., LPN #2 was asked about Resident #2's wound care. They stated they had called hospice three weeks ago to come out and assess the resident. They were asked what they had been doing for a treatment to the wound right hip. They stated they had been applying TAO and covered it. They were asked where that was documented. They stated on the MAR or they would make a progress note. On 08/01/24 at 2:45 p.m., the DON was asked if the policy and procedure titled Treatment Guidelines for Pressure Sores was the current policy and procedure. They stated Yes. They reviewed the policy and procedure and stated there were treatment orders in there to follow. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/01/24 at 3:00 p.m., wound care was observed to be performed by LPN #2. A large open area with a tan drainage was observed to cover the majority of the wound bed. Wound cleanser was applied, bubbles were observed to come out of the wound when LPN #2 applied pressure to cleanse the wound and surrounding tissue. LPN #2 was observed to place a q-tip under the surrounding skin to check for undermining. An odor was noted at the time of wound care. A Skin/Sound Note, dated 08/01/24 at 5:05 p.m., read in part .Resident allowed wound care at this time. Rt hip wound 9.5x9.2x0.5cm unstageable with undermining 2cm at 3 o-clock position with purulent drainage . 2. Resident #17 had diagnoses which included heart disease, dementia, and chronic kidney disease. A quarterly assessment, dated 07/10/24, documented Resident #17 had severe cognitive impairment. A Braden Scale for Predicting Pressure Sore Risk, dated 07/21/24 documented Resident #17 was high risk. A Skin/Wound Note, dated 07/12/24 at 4:45 p.m., read in part, .Resident's rt inner heel has a 1.2 x 1.4cm blood blister. [Name of Hospice withheld] is aware that heels have been breaking down off and on, and DRSG was brought by them for when needed. Iodine applied, and Protective foam DRSG placed. Heels floating, and heel protectors on. T&RQ2H. Ongoing monitoring. Resident #17's physician orders did not document an order had been obtained to start iodine and dressings. Resident #17's nurse progress notes did not contain documentation dressing changes had been completed or a skin assessment had been completed from 07/12/24 through 07/31/24. On 07/31/24 at 9:00 a.m., Resident #17's left heel was observed to have a dried flaky skin area to their left lateral heel and a quarter sized black dry area to their right inner heel. No dressing was observed on either foot. On 07/31/24 at 9:09 a.m., LPN #1 was asked what was in place for prevention. They stated the resident should have heel protectors on. They stated they were not aware Resident #17 had any skin issues until now. No heel protectors were in place. On 07/31/24 at 9:16 a.m., LPN #1 was asked if there had been a skin assessment since 07/12/24. They stated they did not see where one had been completed. They were asked who should be doing the wound care. They stated We should be doing it. They stated they were unaware of the iodine and dressing treatment that had been started. They were asked if the TAR documented to apply iodine and cover with a dressing. They stated there was no order so it won't reflect on the TAR. LPN #2 was asked if Resident #17's wound care was documented it had been provided from 07/12/24 until today. They stated No. On 07/31/24 at 9:58 a.m., LPN #1 stated they had went back and observed Resident #17's right heel and had observed another area. They stated they measured the wounds. The right outer heel was 1.5x1.0, light purple DTI and the inner right heel is a 1.0 x 1.0 cm it is a dark purple DTI. (continued on next page)

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	375571	A. Building B. Wing	08/05/2024

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Wilson Nursing Center	867 US Highway 70a Wilson, OK 73463

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/31/24 at 11:26 p.m., the DON stated they spoke with the Hospice nurse and they were not aware of the wound on Resident #17's heel.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41872 Based on observation, record review, and interview, the facility failed to ensure staff reviewed physician orders prior to administration of medications for two (#22 and #14) of 12 residents observed during medication observation. The Administrator identified 28 residents resided in the facility. Findings: An Injection Insulin policy, dated 05/18/01, read in part .Insulin is used to control blood sugar levels and to facilitate the transport of blood sugar into the cells .Procedure .Check physician's order . 1. Resident #22 had diagnoses which included chronic obstructive pulmonary disease and chronic kidney disease. A physician order, dated 06/04/23, documented to administer Ventolin inhaler two puffs by mouth two times per day. On 08/01/24 at 6:39 a.m., LPN #2 was observed to remove a Ventolin inhaler from the treatment cart for Resident # 22, and administer two puffs to the Resident. They were not observed to check the physician order prior to administration of the medication. 2. Resident #14 had diagnoses which included type two diabetes mellitus and dementia. A physician order, dated 05/18/24, documented to administer Tresiba insulin ten units subcutaneously one time a day. On 08/01/24 at 6:46 a.m. LPN #2 was observed to remove a Tresiba insulin pen for Resident #14, dial up 10 units of insulin then administer it to Resident #14. LPN #2 was not observed to check the physician order prior to administration of the insulin. On 08/01/24 at 6:57 a.m., LPN #2 was asked if the had checked the orders prior to administering Resident #22's inhaler. They stated no, they were use to doing it that way and there was nothing relayed to them at shift change. LPN #2 was asked if they had checked the insulin order prior to administering the insulin. They stated they had not. They were asked if the procedure was followed to check physician orders prior to administering medications. LPN #2 stated No.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 41872 Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for two (#3 and #20) of two sampled residents reviewed for lab results. The Administrator identified 28 residents who resided in the facility. Findings: A Laboratory Services policy, dated 05/18/01, read in part To ensure that laboratory studies performed in the facility are done promptly and accurately . 1. Resident #3 had diagnoses which included type two diabetes mellitus and dementia. An undated physician order, documented to obtain a HGB A1c and a C-Peptide lab on July 1st. The order was not noted by a nurse. A nurse progress lab note, dated 07/08/24 at 2:14 p.m., documented the lab was obtained for a HGB A1c with a C-Peptide and sent to the laboratory. A lab result, dated 07/08/24, documented the HGB A1c was resulted at 9.3. It did not contain documentation of c-peptide results. On 08/01/24 at 7:44 a.m., LPN #2 was asked for Resident #3's C-Peptide results. LPN #2 stated there were no results in the chart for the C-Peptide, they stated they would call the lab for results. The facility did not provide any further documentation for C-Peptide lab results. 2. Resident #20 had diagnoses which included generalized edema, high blood pressure and type two diabetes mellitus. A physician order, dated 07/11/24, documented to obtain a CBC, CMP, CNP, CRP and sed rate. Resident #20's July 2024 treatment administration record documented a 9 on 07/11/24. On 07/30/24 at 9:33 a.m., the IPC nurse was asked if the lab had been drawn. They reviewed the TAR and stated the progress note documented the lab was unable to be collected and would redraw at a later date. They stated We didn't follow up on that. On 07/30/24 at 9:45 a.m., LPN #1 was asked if they were aware if the lab results had been obtained. They stated they had not seen any lab results for the physician order. The clinical health record did not contain documentation the lab had been obtained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46653 Based on observation and interview, the facility failed ensure that food items were properly labeled and stored according to policy. The DON reported 28 resided in the in the facility. Findings: The facility's Safe Food Handling WNC Dietary Department undated, read in part . All food items must be labeled correctly to ensure proper identification and to prevent cross-contamination .Labels must be clear, legible and provide essential information .Label information: Labels must include the following: Product name .Preparation or expiration date .Storage instructions .any Allergen information . On 07/28/24 at 9:06 a.m., there was undated and unlabeled food items in the refrigerator. On 07/28/24 at 9:07 a.m., the Dietary Aide #1 reported bacon, hashbrowns and steak finger were stored in the refrigerator unlabeled and undated. On 07/28/24 at 9:08 a.m., the Dietary Aide #1 reported the food is supposed to be stored with dated and labeled.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41872 Based on record review, and interview, the facility failed to submit direct care staffing payroll data for the PBJ report for 01/01/24 to 03/31/24 (Quarter 2). The Administrator identified 28 residents resided in the facility. Findings: The PBJ Staffing Data Report, dated 01/01/24 through 03/31/24, for Quarter 2 read in part Failed to Submit Data for the Quarter. On 08/02/24 at 8:43 a.m., the administrator was asked who reported the PBJ data for January through March. They stated the Director of Operations had tried to report it but the system was locked, they had missed the deadline. On 08/05/24 at 12:05 p.m., the director of operations was asked was the report sent. They stated, I know we collected it all but when we went in there to submit it, it was closed.

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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. 41872 Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions were in place for one (#17) of one sampled residents reviewed for catheter care. The Administrator identified 28 residents resided in the facility. Findings: Resident #17 had diagnoses which included, dementia, bladder neck obstruction and acute kidney disease. A physician order, dated 10/18/22, documented to cleanse the suprapubic catheter, apply a split gauze bandage around the sp site and secure with tape. A physician order, dated 02/18/22, documented to irrigate the sp catheter with up to 60 cc of normal saline daily. On 07/28/24 at 10:02 a.m., Resident #17 was observed lying in their bed with a catheter bag hanging on the edge of the bed. No signage was posted for EBP precautions, no PPE was observed near Resident #17's door. On 07/30/24 at 1:45 p.m., the IPC nurse was asked what was worn to provide care for Resident #17. They stated they did not use gowns. They had just found out about the EBP precautions yesterday when they completed training. They were asked if EBP precautions had been implemented when staff were providing wound care and catheter care. They stated No. On 07/30/24 at 1:48 p.m.,the IPC nurse provided a copy of a CMS QSO-24-08-NH memo, dated 03/20/24, regarding EBP precautions and stated they had reviewed them.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41872 Based on record review, and interview, the facility failed to ensure the residents were screened, offered and educated about the risks and benefits related to the influenza and pneumococcal vaccination was offered to one (#30) of five sampled residents reviewed for immunizations. The Administrator identified 28 residents resided in the facility. Findings: An undated, Immunizations for Influenza, Pneumonia, and COVID-19 policy and procedure, read in part Influenza .offer the influenza vaccine annually to all residents and staff, ideally before the onset of the flu season .Assess residents for eligibility for the pneumonia vaccine, following CDC guidelines .Provide educational materials about the benefits and potential side effects of the vaccines . Resident #30 had diagnoses which included, high blood pressure, and depression. Resident #30 electronic health record did not contain any documentation Resident #30 had received any immunizations. The hard chart did not contain documentation Resident #30 or the representative had consented or refused the immunizations. On 08/01/24 at 9:41 a.m., the IPC nurse was asked if the resident or their representative had been offered the immunizations. They stated they were unable to find a form for the consent or refusal. They stated it should be documented in computer or the hard chart. On 08/05/24 at 1:28 p.m., The IPC nurse was asked if the residents representative had been educated about receiving the immunizations. They stated, No. The IPC nurse stated that is usually done by SS when the resident was admitted .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41872 Based on record review and interview, the facility failed to screen, offer, and educate on the risks and benefits of the COVID-19 vaccination for one (#30) of five sampled residents reviewed for immunizations. The Administrator identified 28 residents resided in the facility. Findings: An undated, Immunizations for Influenza, Pneumonia, and COVID-19 policy and procedure, read in part Follow CDC and local health department guidelines for COVID-19 vaccinations .Provide educational materials about the benefits and potential side effects of the vaccines . Resident #30 had diagnoses which included, [NAME] blood pressure, and depression. Resident #30 electronic health record did not contain documentation Resident #30 had received any immunizations. The hard chart did not contain documentation Resident #30 or the representative had consented or refused the immunization. On 08/01/24 at 9:41 a.m., the IPC nurse was asked if the resident or their representative had been offered the immunizations. They stated they were unable to find a form for the consent or refusal. They stated it should be documented in computer or the hard chart. On 08/05/24 at 1:28 p.m., the IPC nurse was asked if the residents representative had been educated about receiving the immunizations. They stated, No. The IPC nurse stated that was usually done by SS when the resident was admitted .