STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375579	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Higher Call Nursing Center	407 Whitebird Street Quapaw, OK 74363

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident received pain medication in a timely manner for 1 (#2) of 3 sampled residents reviewed for pain management. The administrator identified 38 residents resided in the facility. Findings:A quarterly assessment, dated 03/09/26, showed Resident #2 had a diagnosis of rheumatoid arthritis and had pain frequently. The assessment showed Resident #2's pain had been rated at a 10/10 within the previous 5 days. The assessment showed Resident #2's cognition was intact with a brief interview for mental status (BIMS) score of 15. An admission summary note, dated 4/26/26 at 2:37 p.m., showed Resident #2 had returned from the hospital at 12:45 p.m. via stretcher and new orders were put into the computer. A physician's order, dated 04/26/26, showed oxycodone (opioid pain medication) 10-325 milligrams one tablet by mouth every six hours as needed for moderate pain. A health status note, dated 04/30/26 at 8:20 p.m., showed the ADON was notified the pharmacy needed a prior authorization for Tresiba (a long-acting insulin) and the ADON stated they would do it in the morning. A 05/2026 medication administration record showed Resident #2 had rated their pain at a 9/10 on 05/01/26 and was therefore provided the oxycodone at 5:30 a.m. The record showed Resident #2 was provided a second dose of oxycodone for pain rated at an 8/10 on 05/01/26 at 1:25 p.m. The record showed Resident #2 did not receive another dose of oxycodone until 05/05/26 at 10:02 a.m. for pain rated at an 8/10. The record was completely blank between the two dates. On 06/01/26 at 1:23 p.m., Resident #2 stated They don't always get our medications ordered timely. The med aide on the weekend slacks off and has a [NAME] attitude. Our meds don't get ordered in time to not have a lapse. My discs are herniated and I take my pain medications through a pain doctor, but they waited until I ran out before they called for a refill. On 06/01/26 at 4:50 p.m., the ADON stated Resident #2 did not get oxycodone fast enough because the pharmacist had car trouble which added a day to delivery, and the insurance wanted a preauthorization that took time. The ADON stated they would provide documentation to show the medication was ordered timely and the facility did what they could. No documentation showing the medication had been ordered timely was provided. On 06/01/26 at 5:45 p.m., the administrator stated they understood if the medication had been reordered timely, then the facility would have had time to provide the requested prior authorization and the pharmacist's car breaking down would not have impacted having the medication available in the facility to provide to Resident #2 as ordered by the physician.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure medications were stored securely. The administrator identified 38 residents resided in the facility. Findings:On 05/28/26 at 1:06 p.m., a clear plastic bag containing multiple different medications waiting for destruction, was observed sitting on the floor of the ADON's office. The ADON's office door was observed to be wide open, and no staff were inside or around the open office door. A Safe Medication Storage, Security, and Temperature Controls policy, dated 05/29/26, read in part, It is the policy of this facility that all medications and biologicals shall be securely maintained under lock and key, stored under strict environmental conditions, and properly labeled at all times. Access to medication storage areas- including regional medication rooms, localized mobile medication carts, and automated dispensing appliances- is restricted exclusively to licensed nursing staff, practitioners, and the Consultant Pharmacist.On 05/28/26 at 1:14 p.m. the ADON stated if the medications are not controlled, the staff bring them to me, and I log and shred them. The ADON stated they would go lock up the medications until they had time to destroy them.On 06/01/26 at 3:45 p.m., the administrator stated they believed the ADON thought it was okay to leave them sitting out because the surveyor was sharing the office with them.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food was palatable for 1 of 2 meals sampled for taste, temperature, and timeliness in being served. The administrator identified 38 residents ate from the kitchen. Findings: On 05/28/26 at 12:57 p.m., the lunch meal provided to the residents, was tasted by the surveyor. The lasagna was observed to have looked like meat with pea size white substances throughout and white yellow cheese across the top. The lasagna had a bad after taste which prevented a second bite. Mixed vegetables were unseasoned and bland, and the garlic bread was a plain piece of white sandwich bread cut diagonally. The kitchen did not have enough lime bars to provide for the surveyor to taste. The menu showed the 05/28/26 lunch meal was to be Italian style lasagna, California vegetable blend, garlic bread, and lime bars. A Food Palatability, Presentation, and Temperature Standards policy, dated 05/29/26, read in part, It is the policy of this organization that all food items prepared and served to residents shall be of the highest culinary quality. Food palatability-encompassing taste, aroma, visual arrangement, texture, and thermal properties -shall be afforded the same operational priority as clinical safety and metabolic accuracy. The facility dietary team, under the supervision of the Certified Dietary Manager (CDM) and consulting Registered Dietitian (RD), shall maintain rigorous quality assurance monitoring via systematic self-auditing and formalized resident feedback mechanisms. On 05/28/26 at 11:30 a.m., the ombudsman stated the food was the biggest complaint they had from the facility, and the rumors of how terrible the food was had even reached other nursing homes. The ombudsman stated there was only one person they spoke with in the facility that did not have issues with the food. On 05/28/26 at 11:45 a.m., Resident #8 gave the thumbs down sign when they were asked about the food. On 5/28/26 at 12:45 p.m., the cook stated they had to improvise on the lasagna because we did not have all of the ingredients. On 05/29/26 at 10:53 a.m., Resident #9 stated the facility did not feed them breakfast, so by lunch they were hungry. Resident #9 stated the facility needed to cook some better food because all they had was sandwiches, sandwiches, sandwiches. On 5/29/26 at 10:31 a.m., Resident #1 stated they were only allowed one piece of sausage at breakfast or one piece of bacon. Resident #1 stated the regional dietary manager kept cutting the budget for the kitchen and now they did not always get enough to eat. On 05/29/26 at 11:20 a.m., Resident #2 stated the place used to be great, but now the food quality was nasty especially on the weekends. Resident #2 stated portions were very small, not even enough to keep a bird alive. Resident #2 stated the regional dietary manager had cut the budget so much that residents could not have seconds. Resident #2 stated since the regional dietary manager came everything had changed in the way of the food. On 06/01/26 at 1:23 p.m., Resident #6 stated the food was bearable, but the facility did not have much for diabetics even with the alternative menu, and the snack cart never had fresh vegetables. Resident #6 stated they ate salads several times last week but would like some fresh vegetables like celery sticks, carrot sticks, or apple slices for a snack instead of cookies, pudding, and snack cakes. Resident #6 stated they loved the cook, but the cook could only do with what they have. On 06/01/26 at 2:34 p.m., the social services director stated they had been at the facility since 09/2025, and the food had been the number one topic for complaints. The social services director stated the amount of food had been an issue because the residents wanted seconds. On 06/01/26 at 5:06 p.m., the cook, via phone, stated they did not have enough sauce, so they used tomato sauce and seasoned it for the lasagna. The cook stated they also did not have the shredded mozzarella, so they used sliced Swiss across the top. The cook stated they had to improvise and be creative probably about two to three times per week. On 06/01/26 at 5:40 p.m., the administrator stated they had spent over the budget on food. The administrator stated the food was one of the last things residents had control over, so it was often the priority for the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food items were stored correctly in the kitchen's refrigerator and freezer and labeled with the preparation and use-by date for 2 of 2 observations.The administrator identified 38 residents received meals from the kitchen.Findings: On 05/28/26 at 12:46 p.m., the following foods were observed in the refrigerator of the kitchen, and then identified by the dietary aide:a. thawed chicken thighs sitting in clear liquid inside an unsecured bag inside of a plastic bin at the bottom of the refrigerator. The date on the bin showed 05/28/26,b. four cracked eggs sitting inside undated cartons in the refrigerator, andc. partially used turkey lunch meat with no label or date in the refrigerator.On 05/28/26 at 12:49 p.m., the following foods were observed in the freezer of the kitchen, and then identified by the dietary aide:a. chicken fajita meat in a twisted closed bag in the freezer with no label or date,b. chicken strips in a twisted closed bag in the freezer with no label or date,c. hamburger patties in a plastic bag inside of a box that was open to air in the freezer with no label or date,d. sausage patties in a plastic bag inside of a box that was open to air in the freezer with no label or date, ande. corn dogs in a twisted closed plastic bag that had a tear leaving the corn dogs open to air in the freezer. There was no label or date on the bag.On 05/29/26 at 8:10 a.m., newly delivered pasteurized eggs in fresh unmarked cartons in the refrigerator were observed to have several cracked eggs. The chicken thighs were no longer present inside the refrigerator.An undated facility policy titled Food Labeling and Date marking, read in part all food containers must include common name of food item, date prepared or opened, discard date and initials of staff member.On 05/28/26 at 12:46 p.m., the dietary aide stated the eggs must have gotten cracked that morning. The dietary aide identified the fajita meat, sausage patties, hamburger patties, and turkey lunch meat. The dietary aide stated the items did not have dates written to indicate when they were opened or when they would need to be removed from rotation. The dietary aide stated the facility did not currently have a dietary manager, but the regional dietary manager came a couple times a week.On 05/28/26 at 12:48 p.m., cook #1 stated the chicken thighs were leftovers from yesterday and they were going to be used later that evening.On 05/29/26 at 8:10 a.m., the regional dietary manager stated staff removed the cracked eggs as they got to them. The regional dietary manager stated all of the open food items were supposed to be closed, labeled, and dated when stored. On 05/29/26 at 8:20 a.m., cook #1 stated they had used the chicken thighs to make chicken salad last night. On 06/01/26 at 3:45 p.m., the administrator stated they had been notified by the regional dietary manager about the food not being labeled or stored correctly.