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	01/09/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure a resident's annual MDS assessment accurately documented the resident's fall history for 1 (#36) of 16 sampled residents whose MDS assessments were reviewed.The DON identified 41 residents received MDS assessments.Findings:A facility policy titled MDS 3.0 Completion, dated August 2024, read in part, According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the state.A progress note, dated 07/30/25 at 3:45 a.m., showed Resident #36 reported they had rolled out of bed onto the floor. The note showed the resident had reported left shoulder pain and right knee pain. The note showed that the resident's right knee appeared slightly larger than the left.A care plan, dated 07/30/25, showed Resident #36 had a fall on 07/30/25. A corresponding intervention in the care plan showed the resident would use a fall mat next to their bed and was educated not to sleep on the edge of their bed.An annual assessment, dated 10/15/25, showed Resident #36 had not had any falls since admission, entry, reentry, or the prior assessment. On 01/08/26 at 2:31 p.m., MDS coordinator #1 reviewed Resident #36's annual assessment, dated 10/15/25, and stated the annual assessment was not accurately coded regarding falls.

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 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: a. prepared food items were labeled with the preparation and use-by dates; b. fresh food items were discarded when wilted and soft to the touch; c. food items were discarded after manufacturer expiration dates; and d. temperature logs were completed for 1 of 2 community refrigerators. The administrator identified 41 residents received meals from the kitchen.Findings:On 01/06/26 at 8:45 a.m., the following observations were made in the refrigerator in the kitchen:a. five serving containers with lids were without labels, preparation, or use-by dates and contained a white pudding type substance,b. two prepared turkey lunchmeat sandwiches, in plastic wrap, were without labels, preparation, or use-by dates,c. an opened one-gallon container of classic Caesar prepared dressing had a manufacturer use-by date of 08/24/25,d. a plastic container with six zucchini squash were wilted and soft to the touch, and e. six heads of iceberg lettuce were wilted, soft to the touch, and discolored. On 01/06/26 at 9:30 a.m., the following observations were made in the south community refrigerator:a. an opened container of mayonnaise with a manufacturer expiration date of 12/04/25,b. an opened container of barbeque sauce with a manufacturer expiration date of 09/21/25, andc. an opened carton of lactose free reduced fat milk without open or use-by dates.On 01/06/26 at 9:33 a.m., a refrigerator log was observed on the South community refrigerator and had no dates or temperatures completed for 01/03/26, 01/04/26, and 01/05/26.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.An undated facility policy titled LTC [Long Term Care] Resident Refrigerator, read in part, write the date you received, date opened, date expired and residents name each food item to keep track.temperature: keep your refrigerator at 40 degrees Faren height or below. when a food item has reached its expiration date, staff must notify the resident and ask whether they would like to discard the item or keep it. The resident must be informed that expired food items may not be returned to the resident refrigerator.On 01/06/26 at 9:10 a.m., the dietary manager stated they knew they were supposed to have items in the refrigerator labelled and dated, but staff had not done it consistently. The dietary manager stated fresh food items should be checked for freshness and discarded if not fresh.On 01/09/26 at 11:09 a.m., the administrator stated housekeeping checked the community refrigerators daily for temperature and once a week for outdated food and cleanliness. The administrator stated they were aware of open dates on the temperature log on the South community refrigerator, and they were not checked.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control was maintained during wound care for 1 (#2) of 2 sampled residents reviewed for wound care.The DON identified 15 residents received wound care.Findings:On 01/08/26 at 12:27 p.m., Resident #2 was observed to receive wound care from RN #1. RN #1 was observed lowering themselves to the floor, onto their knees, then placed both gloved hands, onto the tiled floor. RN #1 was observed to touch Resident #2's bare skin and place a gauze dressing to the resident's left shin. RN #1 was observed to leave the room, while wearing their gown, to apply hand sanitizer from a container outside the room. RN #1 was observed to don gloves halfway onto their hands, reach into their pocket, retrieve a pen, then obtained gauze soaked in Dakin's solution, and placed it onto a wound on the resident's right heel. RN #1 was observed to put on the gloves the rest of the way and wrote the date on a dressing. RN #1 took an iodoform gauze soaked in Dakin's solution, placed it into a wound on the right heel, and applied a boarder gauze dressing with the same gloved hands.An undated facility policy titled Wound Assessment, Treatment, and Monitoring Policy, read in part Wound care shall be performed by licensed nursing staff using clean or sterile technique as ordered.On 01/08/26 at 12:39 p.m., RN #1 stated they had not realized they did not change their gloves correctly. They stated they were not very skilled at dressing changes and did not feel they had a routine down yet.On 01/08/26 at 2:19 p.m., the DON stated RN #1 was nervous and should have better prepared for the wound care.