STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37E568	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Winds Living Center	3718 North Portland Oklahoma City, OK 73112

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. Based on record review and interview, the facility failed to ensure a resident's complete advance directive was included in their medical record for 1 (#2) of 16 sampled residents reviewed for advance directives. RN #1 identified 27 residents resided in the facility. Findings: An advance directive policy, revised 12/2016, read in part, Advance directives will be respected in accordance with state law and facility policy.Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. Resident #2's clinical record contained only one page of their advance directive, dated 04/24/18, which was part four general provisions. The rest of the advance directive was not included in the clinical record. An advance directive acknowledgement form, dated 01/27/24, showed Resident #2 had executed an advance directive. An quarterly resident assessment, dated 02/09/25, showed Resident #2's cognition was intact (BIMS 15). On 05/12/25 at 8:15 a.m., the DON stated Resident #2 had marked the advance directive, but only wanted a DNR. The DON was asked to provide documentation that clarified this information. On 05/12/25 at 9:38 a.m., the social service director stated they knew Resident #2 had an advance directive because the social service director had completed it. They stated they were unsure of where the other pages were. The social services director stated there was a chance when the resident was transferred to the hospital, they did not scan all of the pieces back into Resident #2's chart. On 05/12/25 at 9:40 a.m., the social service director stated they offered resident's the opportunity to formulate an advance directive upon admission. They stated Resident #2 did have the mental capacity to complete an advance directive.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/12/25, a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect a resident from psychosocial abuse for Resident #2. A nurse note, dated 02/13/25 at 4:00 p.m., showed Resident #79 was heard yelling come out your room mother [explicit]. The note showed Resident #79 stated, get out here faggot. The note showed LPN #1 approached Resident #79 who was repeating come the [explicit] out, I'm gonna [explicit] you up. The note showed Resident #79 was holding a wet floor sign in their hand, slinging it around, and attempting to get into another resident's room. The note showed the other resident did nothing and kept their door shut. The note showed Resident #79 threw the wet floor sign at the door which hit LPN #1 on the lower right leg. The note showed three staff attempted to calm them down. The note showed Resident #79 then picked up a chair and threw it towards the door. The note showed the nurse went and got the administrator and DON. The note showed Resident #79 stated, I'm going to [explicit] you up while you sleep mother [explicit]. A nurse note, dated 02/13/25 at 4:58 p.m., showed the ARNP was contacted related to Resident #79's behaviors and gave orders to send the resident to the emergency room for evaluation. A combined initial and final facility reported incident, dated 02/13/25, showed Resident #2 and Resident #79 got into a verbal altercation which caused Resident #79 to get upset. The facility reported incident showed Resident #79 grabbed a chair and threw it at a door. The facility reported incident showed Resident #79 then threw a wet floor sign hitting LPN #1. The facility reported incident showed there were multiple witnesses to the incident. The facility reported incident showed the administrator spoke to Resident #79 in their room. The facility reported incident showed Resident #79 felt bad and apologized to LPN #1. There were no additional resident or staff interviews included in the investigation. A nurse note, dated 02/13/25 at 9:11 p.m., showed Resident #2 was asking if the resident who made prior threats against Resident #2 was out there. It showed LPN #1 informed Resident #2 the resident who made the threats was no longer in the building. The note showed Resident #2 stated, that really scared me, when [they] was yelling outside my door earlier i was getting chest pain and my hands were shaking. The note showed LPN #1 reassured Resident #2 the other resident was not in the building. Resident #2 stated, it just scares me, what if [they] come in here and i'm asleep, I wouldn't even have time to get my call light for help. The note showed, what am i supposed to do, i can't stay awake forever. Resident #2 stated the only time they experienced chest pain was when the other resident was outside their door making threats and calling them names. On 05/12/25 at 12:20 p.m., the Oklahoma State Department of Health (OSDH) determined the existence of a past non-compliance IJ. The facility self identified non-compliance and on 02/27/25 and 03/04/25 in-serviced all facility administrators and DONs regarding abuse, neglect, and exploitation. The facility implemented the following measures in response to the noncompliance: (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. An in-service for abuse, neglect and reporting was held for facility staff on 02/14/25. b. A performance improvement plan was completed on 02/27/25 with the DON, administrator, and ADON which included education on abuse, neglect, misappropriation, and timeline of reporting to the state agency. The performance improvement plan showed the plan included the administrator, DON, ADON, and department heads would review incidents in morning clinical daily to ensure incidents were identified and reported to the administrator to ensure an investigation was initiated and it was reported to the state agency. It showed QAPI would review any issues at least quarterly and make any needed revisions to the plan. The performance improvement plan showed the deadline was 02/27/25. c. Daily clinical meetings which reviewed state reportable incidents started on 03/07/25. They were held March 7th, 10th, 11th, 12th, 13th, 14th, 17th, 18th, 20th, 24th, 25th, 26th, 27th, 28th, and 31st 2025. They were held April 1st, 2nd, 3rd, 4th, 7th, 8th, and 9th 2025, and continued. The daily clinical meetings are a component of the facility's QA. d. A QAPI meeting was held on 03/25/25 which reviewed all reportable incidents up to 03/25/25 with no concerns identified. Based on record review and interview, the facility failed to protect a resident from psychosocial abuse for 1 (#2) of 2 sampled residents reviewed for abuse. RN #1 identified 27 residents resided in the facility. Findings: An undated resident to resident abuse policy, read in part, Facility staff will immediately intervene to halt abusive behaviors and initiate appropriate actions to ensure safety of all residents based on individual occurrence.Remove abusive resident from other residents .Provide 1:1 immediate supervision until problem behavior is alleviated .Transfer to facility of physician preference .Notify local police department if facility is unable to ensure safety of all residents. An admission resident assessment, dated 12/02/24, showed Resident #79's cognition was intact (BIMS 14). A quarterly resident assessment, dated 02/09/25, showed Resident #2's cognition was intact (BIMS 15). A nurse note, dated 02/13/25 at 4:00 p.m., showed Resident #79 was heard yelling come out your room mother [explicit]. The note showed Resident #79 stated, get out here faggot. The note showed LPN #1 approached Resident #79 who was repeating come the [explicit] out, I'm gonna [explicit] you up. The note showed Resident #79 was holding a wet floor sign in their hand, slinging it around, and attempting to get into another resident's room. The note showed the other resident did nothing and kept their door shut. The note showed Resident #79 threw the wet floor sign at the door which hit LPN #1 on the lower right leg. The note showed three staff attempted to calm them down. The note showed Resident #79 then picked up a chair and threw it towards the door. The note showed the nurse went and got the administrator and DON. The note showed Resident #79 stated, I'm going to [explicit] you up while you sleep mother [explicit]. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse note, dated 02/13/25 at 4:58 p.m., showed the ARNP was contacted related to Resident #79's behaviors and gave orders to send the resident to the emergency room for evaluation. A combined initial and final facility reported incident, dated 02/13/25, showed Resident #2 and Resident #79 got into a verbal altercation which caused Resident #79 to get upset. The facility reported incident showed Resident #79 grabbed a chair and threw it at a door. The facility reported incident showed Resident #79 then threw a wet floor sign hitting LPN #1. The facility reported incident showed there were multiple witnesses to the incident. The facility reported incident showed the administrator spoke to Resident #79 in their room. The facility reported incident showed Resident #79 felt bad and apologized to LPN #1. There were no no additional resident or staff interviews included in the investigation. A nurse note, dated 02/13/25 at 9:11 p.m., showed Resident #2 asked if the resident who made prior threats against Resident #2 was out there. The note showed LPN #1 informed Resident #2 the resident who made the threats was no longer in the building. The note showed Resident #2 stated, that really scared me, when [they] was yelling outside my door earlier i was getting chest pain and my hands were shaking. The note showed LPN #1 reassured Resident #2 the other resident was not in the building. The note showed Resident #2 stated, it just scares me, what if [they] come in here and i'm asleep, I wouldn't even have time to get my call light for help. The note showed, what am i supposed to do, i can't stay awake forever. Resident #2 stated the only time they experienced chest pain was when the other resident was outside their door making threats and calling them names. A nurse's note, dated 02/13/25, showed Resident #79 was sent to the hospital for an evaluation. The note showed Resident #79 did not return to the facility. An abuse, neglect, and reporting in-service was completed on 02/14/25 with 12 staff signatures. An abuse in-service was held on 02/27/25 for the administrator of the facility. An abuse in-service was held on 03/04/25 for the DON of the facility. Daily clinical meetings which reviewed state reportable included reportable incidents started on 03/07/25. They were held March 7th, 10th, 11th, 12th, 13th, 14th, 17th, 18th, 20th, 24th, 25th, 26th, 27th, 28th, and 31st. They were held April 1st, 2nd, 3rd, 4th, 7th, 8th, 9th, and continued. A QAPI meeting was held on 03/25/25 which reviewed reportable incidents up to 03/25/25 with no concerns. On 05/07/25 at 8:52 a.m., CNA #1 stated they had received abuse training approximately a month and a half ago. They stated they monitored for resident to resident abuse and staff to resident abuse. On 05/07/25 at 8:53 a.m., CNA #1 stated if abuse was observed or reported to them, they would let the charge nurse and the DON know. On 05/07/25 at 8:54 a.m., LPN #2 stated they received abuse training a month or so ago. They stated they monitored for physical, emotional, sexual, resident to resident, and resident to staff abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/07/25 at 8:55 a.m., LPN #2 stated if abuse was observed or reported to them, they would notify the abuse coordinator who was the administrator. On 05/07/25 at 8:58 a.m., the administrator stated staff were educated on abuse upon hire and throughout the year. They stated at a minimum staff were educated on abuse twice a year. The administrator stated they started working at the facility in March 2025. They stated they monitored for all types of abuse including emotional, physical, and involuntary seclusion. On 05/07/25 at 8:59 a.m., the administrator stated if abuse was observed or reported to them, they would immediately notify the police and start an investigation. They stated they would remove the individual from the facility if it was a staff member until the investigation was complete. The administrator stated staff would immediately protect the resident and complete an assessment. On 05/07/25 at 9:00 a.m., the administrator stated they would notify the state department, police, APS, licensing board, and nurse aide registry of allegations of abuse. On 05/07/25 at 9:01 a.m., the administrator stated the initial report was due within two hours and the final was due within five working days. On 05/07/25 at 9:49 a.m., the director of clinical services stated the facility completed in-services related to abuse with the DONs and administrators of all of their facilities related to abuse, neglect, and reporting. They stated they went over completing safe surveys with residents as part of the investigation. On 05/07/25 at 9:54 a.m., the director of clinical services stated this was part of their QA for all of their facilities. On 05/07/25 at 10:31 a.m., the director of clinical services stated the morning meetings were part of their QA and they reviewed all state reportable incidents. On 05/08/25 at 1:23 p.m., Resident #2 stated Resident #79 was a mouthy person. They stated Resident #79 made people uncomfortable to be around. Resident #2 stated they got into it with Resident #79 at the nurses' station. They stated they went to their room as Resident #79 was Yelling and fussing. Resident #2 stated Resident #79 picked up a sign off of the floor and hit staff in the face with it. Resident #2 stated the event made them feel Uneasy. They stated Resident #79 was sent to the hospital. On 05/08/25 at 1:30 p.m., Resident #2 stated they Have never felt unsafe here. They stated they definitely felt safe at the facility. On 05/08/25 at 1:44 p.m., Resident #2 stated they used to be friends with Resident #79. They stated now Resident #79 was an enemy. On 05/08/25 at 2:13 p.m., LPN #1 stated if abuse was observed or reported to them, they would notify on call which consisted of the administrator and the DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/08/25 at 2:14 p.m., LPN #1 stated Resident #79 was a tantrum [NAME]. They stated Resident #79 was at the nurses' station joking with LPN #1 on 02/13/25. They stated then Resident #79 rolled down the hall and started yelling for Resident #2 to come out because they were going to Whoop [their] [explicit]. LPN #1 stated Resident #2 never came out of their room and their door was never open. They stated Resident #79 escalated to the point of throwing a wet floor sign which bounced off of the door and hit LPN #1. LPN #1 stated Resident #79 then picked up a chair and slung it. LPN #1 stated they went and got the administrator. They stated Resident #2 later spoke to LPN #1 about being scared. On 05/08/25 at 2:16 p.m., LPN #1 stated one of the things Resident #79 had said was they would go into Resident #2's room at night and Beat [their] [explicit]. LPN #1 stated Resident #2 was scared it would happen. LPN #1 stated Resident #79 was already sent out to the hospital at the time Resident #2 reported being scared. LPN #1 reassured Resident #2 they didn't have to worry. On 05/08/25 at 2:17 p.m., LPN #1 stated Resident #79 got sent out on 02/13/25 and had not returned to the facility. LPN #1 stated Resident #2 had only voiced concerns about feeling unsafe with Resident #79 and had not voiced any concerns with any other residents. On 05/12/25 at 9:08 a.m., the director of clinical services stated they had called the previous administrator who was present when the abuse incident between Resident #2 and Resident #79 occurred. They stated the facility completed an in-service the next day on 02/14/25. They stated they addressed the staff immediately. They stated the previous administrator was in the facility at the time and notified the police immediately. They stated Resident #79 was transported to the hospital. On 05/12/25 at 9:11 a.m., the director of clinical services stated Resident #2 notified LPN #1 later on the evening shift they were disturbed by what was going on and what Resident #79 was saying. They stated Resident #79 was already at the hospital at that time and Resident #2 felt secure and safe. On 05/12/25 at 9:14 a.m., the director of clinical services stated the facility staff completed daily rounds related to abuse and neglect to address the concerns. They stated the facility performance improvement plan on 02/27/25 included abuse and neglect. The director of clinical services stated they provided training to staff. They stated Resident #79 was sent out immediately to the hospital after the event. The director of clinical services stated everything was better after Resident #79 left. The director of clinical services stated they had educated staff on the abuse policy, screening residents for signs and symptoms of depression and anxiety, and what to report. On 05/12/25 at 9:28 a.m., the director of clinical services stated they believed the facility did everything they were required to do after the abuse allegation involving Resident #2 and Resident #79. Through staff interviews, in-services and record review it was determined the facility was in compliance as of 03/07/25.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/12/25, a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to thoroughly investigate an allegation of abuse for Resident #2. A nurse note, dated 02/13/25 at 4:00 p.m., showed Resident #79 was heard yelling come out your room mother [explicit]. The note showed Resident #79 stated, get out here faggot. The note showed LPN #1 approached Resident #79 who was repeating come the [explicit] out, I'm gonna [explicit] you up. The note showed Resident #79 was holding a wet floor sign in their hand, slinging it around, and attempting to get into another resident's room. The note showed the other resident did nothing and kept their door shut. The note showed Resident #79 threw the wet floor sign at the door which hit LPN #1 on the lower right leg. The note showed three staff attempted to calm them down. The note showed Resident #79 then picked up a chair and threw it towards the door. The note showed the nurse went and got the administrator and DON. It showed Resident #79 stated, I'm going to [explicit] you up while you sleep mother [explicit]. A nurse note, dated 02/13/25 at 4:58 p.m., showed the ARNP was contacted related to Resident #79's behaviors and gave orders to send the resident to the emergency room for evaluation. A combined initial and final facility reported incident, dated 02/13/25, showed Resident #2 and Resident #79 got into a verbal altercation which caused Resident #79 to get upset. The facility reported incident showed Resident #79 grabbed a chair and threw it at a door. The facilty reported incident showed Resident #79 then threw a wet floor sign hitting LPN #1. The facility reported incident showed there were multiple witnesses to the incident. The facility reported incident showed the administrator spoke to Resident #79 in their room. The facility reported incident showed Resident #79 felt bad and apologized to LPN #1. There were no additional resident or staff interviews included in the investigation. A nurse note, dated 02/13/25 at 9:11 p.m., showed Resident #2 asked if the resident who made prior threats against Resident #2 was out there. The note showed LPN #1 informed Resident #2 the resident who made the threats was no longer in the building. The note showed Resident #2 stated, that really scared me, when [they] was yelling outside my door earlier i was getting chest pain and my hands were shaking. The note showed LPN #1 reassured Resident #2 the other resident was not in the building. Resident #2 stated, it just scares me, what if [they] come in here and i'm asleep, I wouldn't even have time to get my call light for help. It showed, what am i supposed to do, i can't stay awake forever. Resident #2 stated the only time they experienced chest pain was when the other resident was outside their door making threats and calling them names. On 05/12/25 at 12:20 p.m., the Oklahoma State Department of Health (OSDH) determined the existence of a past non-compliance IJ. The facility self identified non-compliance and on 02/27/25 and 03/04/25 in-serviced all facility administrators and DONs regarding the abuse, neglect, and exploitation. The facility implemented the following measures in response to the noncompliance: a. An in-service for abuse, neglect and reporting was held for facility staff on 02/14/25. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	b. A performance improvement plan was completed on 02/27/25 with the DON, administrator, and ADON which included education on abuse, neglect, misappropriation, and timeline of reporting to the state agency. It showed the plan included the administrator, DON, ADON, and department heads would review incidents in morning clinical daily to ensure incidents were identified and reported to the administrator to ensure an investigation was initiated and it was reported to the state agency. It showed QAPI would review any issues at least quarterly and make any needed revisions to the plan. It showed the deadline was 02/27/25. c. Daily clinical meetings which reviewed state reportable incidents started on 03/07/25. They were held March 7th, 10th, 11th, 12th, 13th, 14th, 17th, 18th, 20th, 24th, 25th, 26th, 27th, 28th, and 31st 2025. They were held April 1st, 2nd, 3rd, 4th, 7th, 8th, and 9th 2025, and continued. The daily clinical meetings are a component of the facility's QA. d. A QAPI meeting was held on 03/25/25 which reviewed all reportable incidents up to 03/25/25 with no concerns identified. Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 1 (#2) of 2 sampled residents reviewed for abuse. RN #1 identified 27 residents resided in the facility. Findings: A resident to resident abuse policy, undated, read in part, Facility staff will immediately intervene to halt abusive behaviors and initiate appropriate actions to ensure safety of all residents based on individual occurrence.Remove abusive resident from other residents .Facility Administrator or Director of Nursing will initiate and immediate [sic] investigation of alleged abuse at the time of occurrence including including exploitation, and document findings. An admission resident assessment, dated 12/02/24, showed Resident #79's cognition was intact (BIMS 14). A quarterly resident assessment, dated 02/09/25, showed Resident #2's cognition was intact (BIMS 15). A nurse note, dated 02/13/25 at 4:00 p.m., showed Resident #79 was heard yelling come out your room mother [explicit]. The note showed Resident #79 stated, get out here faggot. The note showed LPN #1 approached Resident #79 who was repeating come the [explicit] out, I'm gonna [explicit] you up. The note showed Resident #79 was holding a wet floor sign in their hand, slinging it around, and attempting to get into another resident's room. The note showed the other resident did nothing and kept their door shut. The note showed Resident #79 threw the wet floor sign at the door which hit LPN #1 on the lower right leg. The note showed three staff attempted to calm them down. The note showed Resident #79 then picked up a chair and threw it towards the door. The note showed the nurse went and got the administrator and DON. The note showed Resident #79 stated, I'm going to [explicit] you up while you sleep mother [explicit]. A nurse note, dated 02/13/25 at 4:58 p.m., showed the ARNP was contacted related to Resident #79's behaviors and gave orders to send the resident to the emergency room for evaluation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A combined initial and final facility reported incident, dated 02/13/25, showed Resident #2 and Resident #79 got into a verbal altercation which caused Resident #79 to get upset. It showed Resident #79 grabbed a chair and threw it at a door. It showed Resident #79 then threw a wet floor sign hitting LPN #1. It showed there were multiple witnesses to the incident. It showed the administrator spoke to Resident #79 in their room. It showed Resident #79 felt bad and apologized to LPN #1. There were no additional resident or staff interviews included in the investigation. A nurse note, dated 02/13/25 at 9:11 p.m., showed Resident #2 was asking if the resident who made prior threats against Resident #2 was out there. It showed LPN #1 informed Resident #2 the resident who made the threats was no longer in the building. The note showed Resident #2 stated, that really scared me, when [they] was yelling outside my door earlier i was getting chest pain and my hands were shaking. The note showed LPN #1 reassured Resident #2 the other resident was not in the building. The note showed Resident #2 stated, it just scares me, what if [they] come in here and i'm asleep, I wouldn't even have time to get my call light for help. The note showed, what am i supposed to do, i can't stay awake forever. The note showed Resident #2 stated the only time they experienced chest pain was when the other resident was outside their door making threats and calling them names. A nurse's note, dated 02/13/25, showed Resident #79 was sent to the hospital for an evaluation. The note showed Resident #79 did not return to the facility. An abuse, neglect, and reporting in-service was completed on 02/14/25 with 12 staff signatures. An abuse in-service was held on 02/27/25 for the administrator of the facility. An abuse in-service was held on 03/04/25 for the DON of the facility. Daily clinical meetings which reviewed state reportable included reportable incidents started on 03/07/25. They were held March 7th, 10th, 11th, 12th, 13th, 14th, 17th, 18th, 20th, 24th, 25th, 26th, 27th, 28th, and 31st. They were held April 1st, 2nd, 3rd, 4th, 7th, 8th, 9th, and continued. A QAPI meeting was held on 03/25/25 which reviewed reportable incidents up to 03/25/25 with no concerns. On 05/07/25 at 8:52 a.m., CNA #1 stated they had received abuse training approximately a month and a half ago. They stated they monitored for resident to resident abuse and staff to resident abuse. On 05/07/25 at 8:53 a.m., CNA #1 stated if abuse was observed or reported to them, they would let the charge nurse and the DON know. On 05/07/25 at 8:54 a.m., LPN #2 stated they received abuse training a month or so ago. They stated they monitored for physical, emotional, sexual, resident to resident, and resident to staff abuse. On 05/07/25 at 8:55 a.m., LPN #2 stated if abuse was observed or reported to them, they would notify the abuse coordinator who was the administrator. (continued on next page)

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	37E568	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Winds Living Center	3718 North Portland Oklahoma City, OK 73112

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/07/25 at 8:58 a.m., the administrator stated staff were educated on abuse upon hire and throughout the year. They stated at a minimum staff were educated on abuse twice a year. They stated they started working at the facility in March 2025. They stated they monitored for all types of abuse including emotional, physical, and involuntary seclusion. On 05/07/25 at 8:59 a.m., the administrator stated if abuse was observed or reported to them, they would immediately notify the police and start an investigation. They stated they would remove the individual from the facility if it was a staff member until the investigation was complete. They stated staff would immediately protect the resident and complete an assessment. On 05/07/25 at 9:00 a.m., the administrator stated they would notify the state department, police, APS, licensing board, and nurse aide registry of allegations of abuse. On 05/07/25 at 9:01 a.m., the administrator stated the initial report was due within two hours and the final was due within five working days. On 05/07/25 at 9:49 a.m., the director of clinical services stated the facility completed in-services related to abuse with the DONs and administrators of all of their facilities related to abuse, neglect, and reporting. They stated they went over completing safe surveys with residents as part of the investigation. On 05/07/25 at 9:54 a.m., the director of clinical services stated this was part of their qa for all of their facilities. On 05/07/25 at 10:31 a.m., the director of clinical services stated the morning meetings were part of their qa and they reviewed all state reportable incidents. On 05/08/25 at 1:23 p.m., Resident #2 stated Resident #79 was a mouthy person. They stated Resident #79 made people uncomfortable to be around. Resident #2 stated they got into it with Resident #79 at the nurses' station. They stated they went to their room as Resident #79 was Yelling and fussing. Resident #2 stated Resident #79 picked up a sign off of the floor and hit staff in the face with it. Resident #2 stated the event made them feel Uneasy. They stated Resident #79 was sent to the hospital. On 05/08/25 at 1:30 p.m., Resident #2 stated they Have never felt unsafe here. They stated they definitely felt safe at the facility. On 05/08/25 at 1:44 p.m., Resident #2 stated they used to be friends with Resident #79. They stated now Resident #79 was an enemy. On 05/08/25 at 2:13 p.m., LPN #1 stated if abuse was observed or reported to them, they would notify on call which consisted of the administrator and the DON. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/08/25 at 2:14 p.m., LPN #1 stated Resident #79 was a tantrum [NAME]. They stated Resident #79 was at the nurses' station joking with LPN #1. LPN #1 stated then Resident #79 rolled down the hall and started yelling for Resident #2 to come out because they were going to Whoop [their] [explicit]. LPN #1 stated Resident #2 never came out of their room and their door was never open. They stated Resident #79 escalated to the point of throwing a wet floor sign which bounced off of the door and hit LPN #1. LPN #1 stated Resident #79 then picked up a chair and slung it. LPN #1 stated they went and got the administrator. They stated Resident #2 later spoke to LPN #1 about being scared. On 05/08/25 at 2:16 p.m., LPN #1 stated one of the things Resident #79 had said was they would go into Resident #2's room at night and Beat [their] [explicit]. LPN #1 stated Resident #2 was scared it would happen. LPN #1 stated Resident #79 was already sent out to the hospital at the time Resident #2 reported being scared. LPN #1 reassured Resident #2 they didn't have to worry. On 05/08/25 at 2:17 p.m., LPN #1 stated Resident #79 got sent out on 02/13/25 and had not returned to the facility. LPN #1 stated Resident #2 had only voiced concerns about feeling unsafe with Resident #79 and had not voiced any concerns with any other residents. On 05/12/25 at 9:08 a.m., the director of clinical services stated they had called the previous administrator who was present when the abuse incident between Resident #2 and Resident #79 occurred. They stated interviews had been misplaced and the old administrator was trying to locate them. The director of clinical services stated the facility completed an in-service the next day on 02/14/25. They stated they addressed the staff immediately. The director of cliica services stated the previous administrator was in the facility at the time and notified the police immediately. They stated Resident #79 was transported to the hospital. On 05/12/25 at 9:11 a.m., the director of clinical services stated the previous administrator did interview residents and staff on 02/13/25. They stated the interviews had not been located. The director of clinical services stated Resident #2 notified LPN #1 later on the evening shift that they were disturbed by what was going on and what Resident #79 was saying. They stated Resident #79 was already at the hospital at that time and Resident #2 felt secure and safe. On 05/12/25 at 9:14 a.m., the director of clinical services stated the facility staff completed daily rounds related to abuse and neglect to address the concerns. They stated the facility performance improvement plan on 02/27/25 included abuse and neglect. The director of clinical servics stated they provided training to staff. They stated Resident #79 was sent out immediately to the hospital after the event. The director of clinical services stated everything was better after Resident #79 left. The director of clinical services stated they had educated staff on the abuse policy, screening residents for signs and symptoms of depression and anxiety, and what to report. On 05/12/25 at 9:20 a.m., the director of clinical services stated the performance improvement plan did not specifically address missing interviews, because the previous administrator had completed interviews and safe surveys related to this abuse investigation, and was just unable to locate them. The director of clinical services stated the previous administrator usually attached the interviews and safe surveys with the state reportable incident report and failed to do so this time. On 05/12/25 at 9:28 a.m., the director of clinical services stated they believed the facility did everything they were required to do after the abuse allegation involving Resident #2 and Resident #79. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Through staff interviews, in-services and record review it was determined the facility was in compliance as of 03/07/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure resident's oxygen tubing was changed according to the standard of practice and physician order for 1 (#18) of 1 sampled resident reviewed for oxygen use. RN #1 identified 27 residents resided in the facility. Findings: On 05/04/25 at 8:40 a.m., Resident #18 was observed wearing oxygen. The tubing had a piece of tape with red writing that showed 3/23/25. On 05/08/25 at 10:01 a.m., Resident #18 was observed wearing oxygen. The tubing had a piece of tape with red writing that showed 3/23/25. Resident #18's physician order, dated 06/02/24, showed to Change oxygen tubing and humidifier bottles every week on Sunday 11/7 shift every night shift every Sunday. Resident #18's physician order, dated 01/15/25, showed Oxygen 2L/min via nasal cannula as needed. Resident #18's care plan, revised 01/22/25, showed oxygen at 2L per nasal cannula as needed. Resident #18's quarterly resident assessment, dated 04/13/25, showed oxygen use, and diagnoses which included chronic obstructive pulmonary disease and chronic respiratory failure. On 05/08/25 at 10:02 a.m., Resident #18 stated they did not recall when the tubing was last changed and stated it was probably time to change it. On 05/08/25 at 10:07 a.m., LPN #2 stated the oxygen tubing was to be changed out on the 11-7 shift every Sunday and as needed. On 05/08/25 at 10:09 a.m., LPN #2 went to Resident #18's room and stated the oxygen tubing showed 03/23/25, and was not dated appropriately. On 05/08/25 at 10:09 a.m., the DON stated the oxygen tubing was to be changed every Sunday. The DON stated they ensured the tubing was changed when they made their compliance and angel rounds.

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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. Based on record review and interview, the facility failed to ensure a resident was not administered the wrong medications for 1 (#4) of 6 sampled residents reviewed for medication administration. RN #1 identified 27 residents resided in the facility. Findings: An administering medications policy, revised 04/2019, read in part, Medications are administered in a safe and timely manner, and as prescribed.Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. A medication error form for Resident #4, dated 02/07/25, read in part, at approximately [7:45 p.m.] acma came to this nurse and reported that a different resident's evening meds were missing, upon investigation this nurse found that meds were not missing they were given to this resident [Resident #4], and were administered at approximately [4:30 p.m.], vs obtained at [7:50 p.m.] t-97.3, bp- 120/77, p-83, resp even unlabored at 20, o2 sat 96% on r/a, fsbs-37 [error], resident alert and oriented to person, place and situation, as is normal for this resident, pleasant mood, gait slow and steady, tremor observed to both hands, not abnormal for this resident .when asked does say [they] feels like [their] heart is racing, this nurse called [pharmacy] and spoke with pharmacist r/t possible ase at approx [8:00 p.m.], [they] said that [they] should be fine and that [they] could feel like [their] heart is racing, be drowsy/sleepy, spoke with [Physician #1] and was told to keep [them] in observation for 24 hours, administrator updated, vs at [9:30 p.m.] t-97.3, bp-137/88, p-70, resp even and unlabored at 20, no drowsiness, very alert, does say [they] still feels like [their] heart is racing, fsbs 131. The form was completed by LPN #1. The February 2025 FSBS injection log showed Resident #4's FSBS on 02/07/25 at 5:30 p.m. was 137. An updated medication error form for Resident #4, dated 02/07/25, was provided to the surveyor on 05/12/25. The form amended the FSBS of 37 to 137, and added the following information: the following medications were admin, duloxetine (an antidepressant), melatonin (a hormone that regulates sleep), clozapine (an antipsychotic), dicyclomine (a medication used to relax the smooth muscles of the intestine), metformin (a medication used to treat diabetes). Resident that has [their] medications given in error, [Resident #6], did receive [their] medications without delay. An order summary report, dated 05/06/25, showed Resident #4 had diagnoses which included anxiety disorder, major depressive disorder, diabetes mellitus, and bipolar disorder. On 05/08/25 at 11:50 a.m., CMA #1 stated the facility had bubble packs for medication administration that included each resident's medications. They stated they would verify the name, the resident's pictures, and go through the resident's medication orders to ensure residents received the correct medications. On 05/08/25 at 11:50 a.m., CMA #1 stated if they identified a resident received the wrong medications they would report it to the charge nurse. They stated they were not aware of an event when Resident #4 received the wrong medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/25 at 11:54 a.m., LPN #2 stated staff were to follow the medication administration record to ensure residents received the correct medications. They stated if staff identified a resident received the wrong medications, they should notify the nurse. LPN #2 stated the nurse would notify the DON and complete a medication error incident report. On 05/08/25 at 11:55 a.m., LPN #2 stated they were not aware of any instance where Resident #4 received the wrong medications. On 05/08/25 at 12:17 p.m., the DON stated staff utilized the medication administration record and the rights for medication administration to ensure residents received the right medications. The director of clinical services stated there was also a photo of the resident for staff to refer to. The director of clinical services stated staff could also ask the resident to verify their name and date of birth . On 05/08/25 at 12:18 p.m., the DON stated the medication aides passed most of the medications to the residents. The DON stated if they identified a resident received the wrong medication they were to immediately notify the nurse. The DON stated the nurse would assess the resident, notify the provider, family, and monitor the resident. The DON stated the medication error form, dated 02/07/25, did not identify what medications Resident #4 received in error or whose medications they received. On 05/08/25 at 12:19 p.m., the director of clinical services stated when the medication error form was vague, it was hard to know. On 05/08/25 at 12:23 p.m., the DON stated staff notified the doctor and the family, if they had any, of the medication error. On 05/08/25 at 12:53 p.m., the director of clinical services stated they knew staff called Physician #1 after the medication error. They stated they could not see where they identified what medications were given. The director of clinical services stated Resident #4 was placed on observation. They stated they would update the incident report once they identified the medications that were given. On 05/08/25 at 2:18 p.m., LPN #1 stated resident medications came in a bag from pharmacy with their name and the medications listed on each bag in order to cut down on medication errors. On 05/08/25 at 2:19 p.m., LPN #1 stated if a resident received the wrong medications, they would call pharmacy first to speak with a pharmacist to see what side effects they needed to monitor for. They stated then they would notify the physician and update them on the resident's status. On 05/08/25 at 2:20 p.m., LPN #1 stated the medication aide had come to them the night of 02/07/25 and informed them they did not have Resident #6's medications to administer. LPN #1 stated they called pharmacy to inform them they did not have the medications, and pharmacy reported they had sent the medications to the facility. LPN #1 stated they looked through the medication cart and when they came to Resident #4's spot in the cart, all of their medications were still there for the evening dose. LPN #1 stated they asked the medication aide if they had given everyone their medications except Resident #6 and they stated they had. LPN #1 stated that was when they figured out Resident #4 had received Resident #6's medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/25 at 2:20 p.m., LPN #1 stated Resident #4 was administered the following medications in error: duloxetine, melatonin, clozapine, dicyclomine, and metformin. LPN #1 stated the medications were the routine evening medications for Resident #6. On 05/08/25 at 2:23 p.m., LPN #1 stated they called pharmacy and spoke with the pharmacist. They stated they notified the provider and the DON at the time. LPN #1 stated Resident #4 was pulled into focused charting where staff monitored them for the next three days to ensure they did not have any adverse reactions to any of the medications. LPN #1 stated they did not observe any adverse reactions. They stated Resident #4's vital signs were stable, there was no grogginess or staggering experienced. LPN #1 stated Resident #4 was diabetic so they monitored their blood sugars and had no issues. On 05/08/25 at 2:24 p.m., the director of clinical services stated they unlocked the 02/07/25 incident report for Resident #4 and added what medications were involved in the incident and the provider was notified of the medications involved.

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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 EBP (Enhanced Barrier Precaution) signage was in place to ensure appropriate usage of PPE, for 1 (#24) of 1 sampled resident reviewed for infection control. RN #1 identified 27 residents resided in the facility. On 05/04/25 at 8:17 a.m., Resident #24 was observed in their room, on their bed under the covers, and did not respond to questions. No observation of EBP signage inside the residents room or anywhere outside of the residents room. On 05/05/25 at 12:33 p.m., there was no EBP signage on the outside of Resident #24's room/door. There was a three drawer plastic cabinet in the hall located next to the room which contained gowns, shields, masks, and gloves. Resident #24 stated the staff tape the port for showers. A resident admission assessment, dated 03/10/25, showed Resident #24 received dialysis, was cognitively intact with a BIMS of 15, and had diagnosis of end stage renal disease. A physicians order, dated 03/06/25, showed Enhanced Barrier Precautions every shift related to end stage renal disease. A policy titled Infection Prevention and Control Program, dated 03/19/25, read in part, This policy has established and maintains an infection prevention control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. A physicians order, dated 05/06/25 showed dialysis Tuesday, Thursday, and Saturday. On 05/05/25 at 12:35 p.m., Resident #24 stated it depended on the person if a mask was worn when facility staff tended to the dialysis catheter. Resident #24 stated facility staff never wore a gown when tended to the dialysis catheter. On 05/05/25 at 1:51 p.m., CNA #1 stated the little cabinets in the hallway were for isolation and COVID. They stated there were two residents on EBP for dialysis. When asked how to know who was on EBP, CNA #1 stated there was suppose to be a sign on the outside of the door and was a blue sign. CNA #1 stated the residents take them down. Went inside the room with CNA. CNA #1 stated there was no EBP signage for the residents room. On 05/05/25 at 1:55 p.m., LPN #2 stated there were two residents on EBP and were suppose to have signs up close to the room. They stated Resident #24 did not currently have signage for EBP. LPN #2 stated it had been the DONs responsibility to put up the signage. On 05/05/25 at 2:06 p.m., the DON stated there were two residents on EBP for dialysis. The DON stated there was a paper on the front of the residents door, not inside, and on the isolation cart. The DON stated there was a blue sign on the door and the isolation cart, and it was the first thing done. The DON stated the social services director helped put them out. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/05/25 at 2:09 p.m., the DON stated the residents remove the signs. On 05/05/25 at 2:11 p.m., the DON went to Resident #24's room and stated there was no signs.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to utilize an infection assessment screening to identify whether or not antibiotics were necessary for 2 (#6 and #10) of 5 sampled residents reviewed for antibiotic stewardship. The Resident Matrix, dated 05/04/25, showed 11 residents with infections resided in the facility. Findings: An infection prevention and control program policy, dated 05/12/23, read in part, An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program .Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. The January 2025 infection surveillance showed Resident #6 received zithromax (an antibiotic) 250 mg for an upper respiratory infection started on 01/16/25. It showed Resident #10 received azithromycin (an antibiotic) 250 mg started on 01/18/25. There were no laboratory results or infection assessment screening located in the residents' clinical record for the above antibiotic use. The February 2025 infection surveillance showed Resident #10 received doxycycline hyclate (an antibiotic) 100 mg for a skin infection started on 02/26/25. There were no laboratory results or infection assessment screening located in the resident's clinical record for the above antibiotic use. On 05/05/25 at 11:40 a.m., the DON and director of clinical services stated the facility utilized the McGreer screening for antibiotic stewardship. On 05/05/25 at 11:44 a.m., the director of clinical services stated it was under assessments in the clinical record and was titled infection screening evaluation. They stated the last infection screening evaluation for Resident #6 was completed on 09/10/24. They stated the facility utilized both the Loeb and McGreer screening. On 05/05/25 at 1:00 p.m., the DON stated they had started at the facility in March 2025. They stated staff would utilize laboratory results and any other results from residents and log them in the infection screening tool as well as the infection control log to track infections in the building. On 05/05/25 at 1:02 p.m., the DON stated it was their understanding the facility utilized the screening tools to help with antibiotic stewardship. They stated they also encouraged hydration to residents and education and in-services on infection control and antibiotic stewardship. The DON stated they would go by whatever the doctor said. They stated staff would send the doctor the lab results and culture and sensitivity and then the doctor would decide based on the individual's history and medications. On 05/05/25 at 1:04 p.m., the DON stated the facility identified the antibiotics were appropriate for Resident #6 and Resident #10 Because the doctor said. The DON reviewed both resident records and stated they did not locate any antibiotic screening tool used for either resident's infection in January 2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37E568	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Winds Living Center	3718 North Portland Oklahoma City, OK 73112

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/05/25 at 1:07 p.m., the DON stated they did not locate an antibiotic screening tool for Resident #10's infection in February 2025.