STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37E624	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Callaway Nursing Home	1300 West Lindsey Sulphur, OK 73086

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure a resident's representative was notified of physical restraint use for 1 (#1) of 3 sampled residents reviewed for change in condition. The administrator reported 43 residents resided in the facility. Findings: An undated facility policy titled Notification of Changes showed the facility must immediately inform the resident representative when there was a significant change in the resident's physical, mental or psychosocial status. The policy showed the facility must immediately inform the resident's representative when a need to alter treatment significantly. An annual assessment, dated 04/01/25, showed Resident #1's cognition was moderately impaired with a BIMS score of 09. A progress note, dated 04/28/25 at 5:29 p.m., showed the nurse practitioner ordered to send Resident #1 to an inpatient psych facility and ordered a wrist restraint. A progress note, dated 04/28/25 at 6:31 p.m., showed Resident #1's family was notified of the resident's behaviors, order to send to an inpatient psych facility, and new order for a wrist restraint. An admission record/face sheet, dated 05/02/25, showed diagnoses which included cerebral palsy and intellectual disabilities. The admission record/face sheet showed family member #1 was the resident's responsible party/POA and emergency contact #1. On 05/01/25 at 12:15 p.m., family member #1 reported they had not been notified by the facility about the behaviors Resident #1 was having, the order for the wrist restraint, or the referral for the inpatient psych facility. On 05/01/25 at 1:56 p.m., the ADON reported the resident's representative/POA was not notified by the charge nurse related to the resident's behaviors, the order for the wrist restraint and the referral for inpatient psych facility. The ADON reported another family member was contacted, but not the POA. The ADON reported the resident's representative/POA should have been contacted.

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

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was not physically restrained for 1 (#1) of 1 sampled resident reviewed for physical restraints. The administrator reported 43 residents resided in the facility. Findings: An undated facility policy titled Use of Restraints showed unless there was an actual emergency, a physical restraint would not be initiated until the need for such a restraint was discussed thoroughly with the resident and/or representative and written consent is obtained. The policy showed the resident, or resident representative has the right to refuse the use of a restraint. An annual assessment, dated 04/01/25, showed Resident #1's cognition was moderately impaired with a BIMS score of 09. The assessment showed limited range of motion to one side of upper extremity and staff asssistance required with activities of daily living. A progress note, dated 04/28/25 at 5:12 p.m., showed Resident #1 was sitting in their room and placed four fingers down their throat which caused them to vomit. The note showed while gagging, the resident continued to put their hand down their throat six times. A progress note, dated 04/28/25 at 5:29 p.m., showed the nurse practitioner ordered to send Resident #1 to an inpatient psych facility and for a wrist restraint. A progress note, dated 04/28/25 at 7:15 p.m., showed Resident #1 was sitting in front of the nurses station under supervision due to self harm. The note showed the resident had been screaming and yelling wanting to got back to their room. A progress note, dated 04/28/25 at 7:52 p.m., showed the restraint was removed and the nurse would continue to monitor the resident's behavior. A progress note, dated 04/28/25 at 8:08 p.m., showed the restraint was put back on because the resident continued to cause self harm and hitting/cussing staff members. A progress note, dated 04/28/25 at 8:23 p.m., showed Resident #1 was up in their wheelchair at the nurses station yelling and cussing staff members, wanting to go to their room, and needing a drink every minute. The note showed the resident stated they promised to not put their fingers down their throat again. A progress note, dated 04/28/25 at 8:38 p.m., showed the Resident #1 remained in a restraint due to multiple failed attempts to remove due to the resident causing harm to self and staff members. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 04/28/25 at 9:51 p.m., showed Resident #1 had the restraint removed at 9:30 p.m. and the resident promised not to cause harm to self or others. The note showed the resident was put to bed at approximately 9:44 p.m. and about seven minutes later the resident put their fingers down their throat which caused them to vomit all over themselves. The note showed the restraint was placed back on the resident. A progress note, dated 04/29/25 at 12:13 a.m., showed the restraint was removed and family present. The note showed shortly after the family member left the facility the resident put their hand down their throat and made themselves throw up. The note showed the restraint was put back on. An admission record/face sheet, dated 05/02/25, showed diagnoses which included cerebral palsy and intellectual disabilities. The admission record/face sheet showed family member #1 was the resident's responsible party/POA and emergency contact #1. On 05/01/25 at 1:56 p.m., the ADON reported the charge nurses working at the time the wrist restraint was used had been put on suspension pending an investigation. On 05/01/25 at 2:55 p.m., the MDS coordinator reported no restraints were to be used in the facility for any reason. The MDS coordinator reported not being aware what was used as a restraint due to the facility did not have any type of restraint in house. On 05/01/25 at 3:00 p.m., the administrator reported an investigation was ongoing related to the use of the restraints, staff involved had been suspended, and all staff had been in-serviced related to facility policy of no restraints. On 05/02/25 at 9:46 a.m., family member #2 reported when they arrived to the facility on [DATE] around midnight, the resident was sitting by the nurses station and the nurse was observed to remove something tied around the resident's right wrist. Family Member #2 reported the resident did not have use of their left arm. Family Member #2 reported the resident appeared to have been crying and was tired, and kept saying they wanted to go to sleep, but staff had tied their arm up and would not let their arm out. Family Member #2 reported the resident had been complaining of stomach pain since 04/27/25 and it was apparent the restraint caused them mental distress.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/02/25 at 10:52 a.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy situation related to the facility's failure to effectively assess, monitor, and intervene for Resident #1's failure to have a bowel movement which likely caused the resident to be admitted to the hospital with a small bowel obstruction. On 05/02/25 at 11:14 a.m., the receiver, ADON and MDS coordinator were notified of the immediate jeopardy and provided the immediate jeopardy template. On 05/05/25 at 7:05 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Plan Of Removal 5/02/2025: 1. Systemic changes implemented: a. All residents with no bowel movement within the previous 3 days were immediately physically assessed and educated on the risks and benefits of proper hydration or lack of same for daily bowel movements. b. Physician notified and orders received for medication if applicable. c. Medications administered, as ordered. d. Continue to assess affected resident every 2 hours until bowel movement occurs. If no bowel movement within 24 hours of first medication administration, notify physician and send to emergency room for further evaluation. e. If bowel movement occurs within 72 hours, nurse will document bowel sounds and bowel movements, and update physician. 2. Process/Systems involved: a. Policy for Bowel Movement Monitoring was implemented on 5/2/2025. A copy of the policy is attached to this document as Exhibit A. b. CNAs will notify Charge Nurse if any resident does not have a bowel movement during their shift. Charge Nurse will document same on 24-hour report. Resident will be encouraged to hydrate more by Charge Nurse and CNAs. Charge Nurse will educate resident on importance of proper hydration and bowel movement. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Charge Nurse will review PCC/POC dashboard at shift change and identify any residents who has not had a bowel movement within the previous 3 days. Charge Nurse will continue to assess affected resident every 2 hours until bowel movement occurs. If no bowel movement occurs within 24 hours of first medication administration notify physician and send to emergency room for further evaluation. d. PCC/POC dashboard to be discussed daily at Stand-up Meeting. DON and/or ADON will review PCC/POC Dashboard with Charge Nurse daily and track documentation for potential bowel issues. 3. Factors involved: POLICY - new policy attached as Exhibit 'A' PEOPLE: All Nurses, CMAs and CNAs were in serviced on new Bowel Movement Policy 4. Actions taken/Planned to be taken: a. All Nurses, CMAs, and CNAs were in serviced or will be in serviced On reporting process for residents with no bowel movements in previous 24 hours Staff in-serviced during shift change at 2 p.m. on 5/2/25, along with all agency staff in-serviced and acknowledged utilizing agency's communication app by 6:30 pm on 5/2/25. b. CNAs will notify Charge Nurse if any resident does not have a bowel movement during their shift. Charge Nurse will document same on 24-hour report. Resident will be encouraged to hydrate more by Charge Nurse and CNAs. Charge Nurse will educate resident on importance of proper hydration and bowel movement. c. Charge Nurse will review PCC/POC dashboard at shift change and identify any residents who has not had a bowel movement within the previous 3 days. Charge Nurse will continue to assess affected resident every 2 hours until bowel movement occurs. If no bowel movement occurs within 24 hours of first medication administration notify physician and send to emergency room for further evaluation. d. PCC/POC dashboard to be discussed daily at Stand-up Meeting. DON and/or ADON will review PCC/POC Dashboard with Charge Nurse daily and track documentation for potential bowel issues. e. Information to be reviewed during QAPI [quality assurance and performance improvement] meeting. 5. Date Action Taken 5/2/2025 6. Staff Education plan: Staff in-serviced on Bowel Movement Policy, reporting to Charge Nurses any resident who has had no Bowel Movement in their shift, and encouraging residents to hydrate properly. Nurses were in-serviced on educating residents on risks and benefits of proper hydration and bowel movements. All nursing staff in-serviced on proper documentation of bowel movements. Staff in-serviced during shift change at 2pm on 5/2/25, along with all agency staff in-serviced and acknowledged utilizing agency's communication app by 6:30 pm on 5/2/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Mode of education: Person to person in-service, as well as written materials available for review. 8. Monitoring of implemented actions: PCC/POC Dashboard will be monitored daily by Corporate Compliance Officer, Administrator, Director of Nurses and/or Assistant Director of Nurses to ensure Adherence to Bowel Movement Policy is occurring. PCC progress notes will be monitored daily by the Corporate Compliance Officer, Director of Nurses and/or Assistant Director. On 05/05/25 after interviews with facility staff and review of in-services, the immediacy was lifted, effective 05/02/25 at 6:30 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to assess, monitor, and intervene for a resident with no bowel movements to prevent a bowel obstruction for 1 (#1) of 3 sampled residents reviewed for bowel movements. The receiver reported 43 residents resided in the facility. Findings: A care plan, dated 07/31/24, showed Resident #1 had diagnoses of constipation. The care plan showed to check bowel sounds if no bowel movement for three days and notify physician for any further interventions. An annual assessment, dated 04/01/25, showed Resident #1's cognition was moderately impaired with a BIMS score of 09. The assessment showed the resident was always incontinent of bowel and required assistance from staff for activities of daily living. A bowel elimination record, dated 04/02/25 through 04/30/25, showed Resident #1 had no bowel movement on 04/22/25, 04/23/25, 04/24/25, 04/25/25, and 04/26/25. The record showed the resident had a medium sized bowel movement on 04/27/25. A progress note, dated 04/28/25 at 2:44 a.m., showed Resident #1 stated they felt nauseous. The note showed the resident had no further vomiting episodes. A progress note, dated 04/28/25 at 9:37 a.m., showed Resident #1 had vomited times two, a moderate amount, and chunks of food. The note showed Zofran (anti-nausea medication) was given and the nurse practitioner was notified. A progress note, dated 04/28/25 at 10:13 a.m., showed vomiting continued at that time. A progress note, dated 04/28/25 at 10:16 a.m., showed Resident #1's blood pressure was 128/100 and pulse was 110. The progress note showed complete blood count (CBC), urinalysis (UA), and comprehensive metabolic panel (CMP) was ordered by the nurse practitioner. A progress note, dated 04/28/25 at 1:10 p.m., showed a nurse aide reported to nurse Resident #1 was seen putting their finger down their throat making themselves vomit. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A bowel elimination record, dated 04/28/25 and 04/29/25, showed no bowel movement. A progress note, dated 04/29/25 at 12:42 p.m., showed Resident #1 was transferred to the emergency room for self harm, altered mental status, and low blood pressure. A computed tomography (CT) of abdomen and pelvis without contrast exam, dated 04/29/25, showed marked fluid distention/dilation of the stomach and small bowel to rough area of transition in the anterior/central abdomen, suggestive of high-grade bowel obstruction. The exam showed a recommendation for surgical evaluation. An admission record/face sheet, dated 05/02/25, showed diagnoses which included cerebral palsy and intellectual disabilities. On 05/01/25 at 12:15 p.m., family member #1 reported family member #2 had been to the facility on [DATE] and Resident #1 would not eat and complained of their stomach hurting. On 05/01/25 at 2:45 p.m. CNA #1 reported Resident #1 usually had a hard time having bowel movements. CNA #1 reported if a resident asked for medication for constipation they would inform the nurse. CNA #1 also reported they should report no bowel movements for three days to the nurse. On 05/01/25 at 2:50 p.m., CMA #1 reported if the CNA reported a resident was having issues with constipation or if the resident asked for medication for constipation, and they had an order, it would be administered. CMA #1 reported no bowel movement for two days would warrant a need for medication. CMA #1 reported not having access to the electronic medical record to see residents' bowel movements. On 05/01/25 at 3:00 p.m., the ADON reported the electronic medical record should notify all staff if a resident had not had a bowel movement for three days. The ADON reported all staff were responsible for looking for this notification in the electronic medical record. The ADON reported the nurse should notify the CMA if the resident had no bowel movement for three days to give a PRN medication for constipation or contact the physician for an order. On 05/01/25 at 3:15 p.m., LPN #1 reported the electronic medical record notified the CNAs if the resident had not had a bowel movement for three days. LPN #1 reported an assessment should be done and bowel sounds listened if a resident was not having bowel movements. LPN #1 reported nurses were not alerted by the electronic medical record if residents had no bowel movements for three days unless a CNA reported it to them. On 05/01/25 at 3:45 p.m., the MDS coordinator reported a nurse assessment should have been completed for Resident #1 not having a bowel movement for five days and having vomiting. The MDS coordinator reported vomiting with no bowel movements could have been an indication of a small bowel obstruction. On 05/01/25 at 4:00 p.m., the ADON reported the facility had no policy for assessing and monitoring bowel movements. The ADON reported the start of the fourth day of no bowel movements would be when staff should start to intervene. The ADON reported Resident #1 should have had a nursing assessment done with their vomiting. The ADON reported no nursing assessment had been documented in Resident #1's record related to the vomiting or no bowel movement. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/02/25 at 9:46 a.m., family member #2 reported Resident #1 had been complaining of stomach pain since 04/27/25. Family Member #2 reported the nurse had been informed on 04/27/25 by the family the resident was complaining their stomach was hurting and would not eat. Family member #2 reported going to the facility on [DATE] around midnight because the facility had reported the resident was having behaviors of making self vomit and the physician had ordered physical restraints and a referral for an inpatient psych evaluation. Family Member #2 reported the resident was sitting by the nurses station and had been crying, was tired and asking to go to bed. Family Member #2 reported the resident had been admitted to the hospital with a small bowel obstruction and had not had surgical intervention at this time.