STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375144	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Creek Skilled Nursing & Therapy	2300 Iowa Avenue Chickasha, OK 73023

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46216 Based on observation and interview the facility failed to ensure residents right to privacy in their rooms for 2 (#27 and #39) of 3 sampled residents observed for resident rights. The administrator identified 76 residents resided in the facility. A Essentials of Resident Rights policy, dated 2020, read in part, Each resident has the right to enjoy privacy in their room. Always knock before entering a room, and if the resident is able to respond, wait for a response. Knock even when the door is open and the resident can see you, or if the resident cannot respond to let them know you are there. 1. Resident #39 had diagnoses which included chronic obstructive pulmonary disease and type two diabetes mellitus with diabetic neuropathy. Resident #39's significant change assessment, dated 01/11/25, showed the resident required partial/moderate to total assistance with their ADLs. On 02/05/25 at 10:16 a.m., LPN #1 sanitized their hands and entered the resident's room to obtain a FSBS. LPN #1 did not knock prior to entering the resident's room. 2. Resident #27 had diagnoses which included chronic congestive heart failure and type two diabetes mellitus with diabetic neuropathy. Resident #27's admission assessment, dated 01/01/25, showed the resident required one to two person assistance with their ADLs. On 02/05/25 at 10:23 a.m., LPN #1 sanitized their hands and entered the resident's room to obtain a FSBS. LPN #1 did not knock prior to entering the resident's room. On 02/05/25 at 10:28 a.m., LPN #1 stated they stated the policy for ensuring privacy and dignity for residents was to knock prior to entering room. They stated they did not knock on the residents doors prior to entering.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375144	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Creek Skilled Nursing & Therapy	2300 Iowa Avenue Chickasha, OK 73023

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. 49701 Based on record review and interview, the facility failed to ensure resident assessments were accurate for 1 (#8) of 18 assessments verified for accuracy. The administrator identified 76 residents resided in the facility. Findings: Resident #8 had diagnoses which included end stage renal disease. A physician's order, dated 02/22/24, showed dialysis: schedule visits to dialysis on Monday, Wednesday, and Friday at 6:30 a.m. at Anadarko for now. A nurse progress note, dated 02/23/24, read in part, resident continues dialysis Monday Wednesday and Friday. Resident continues to have fistula to left arm. An admission assessment, dated 02/28/24, showed the resident was not going to dialysis. On 02/05/25 at 8:19 a.m., the MDS coordinator stated the admission assessment documented Resident #8 was not on dialysis, but they have been since they arrived at the facility. On 02/06/25 at 9:59 a.m., the DON stated, I would expect the MDS to accurately reflect the residents condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375144	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Creek Skilled Nursing & Therapy	2300 Iowa Avenue Chickasha, OK 73023

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46216 Based on observation record review, and interview, the facility failed to follow their policy on insulin administration for 2 (#27 and #39) of 3 sampled residents reviewed for medication administration. The DON identified 20 residents residing in the facility received insulin. Findings: A Medication Administration-General Guidelines policy, dated 01/2022, read in part, The person who prepares the dose for administration is the person who administers the dose. 1. Resident #39 had diagnoses which included chronic obstructive pulmonary disease and type two diabetes mellitus with diabetic neuropathy. Resident #39's significant change assessment, dated 01/11/25, showed the resident required partial/moderate to total assistance with their ADLs. On 02/05/25 at 10:16 a.m., LPN #1 sanitized their hands and entered the resident's room to obtain a FSBS. The resident's FSBS was 174. LPN #2 drew 10 units of Lantus into the insulin syringe and 2 units of regular insulin into another insulin syringe. LPN #2 verified the insulins with LPN #1 then handed both syringes to LPN #1. LPN #1 administered both insulins to Resident #39. 2. Resident #27 had diagnoses which included chronic congestive heart failure and type two diabetes mellitus with diabetic neuropathy. Resident #27's admission assessment, dated 01/01/25, showed the resident required one to two person assistance with their ADLs. On 02/05/25 at 10:23 a.m., LPN #1 sanitized their hands and entered the resident's room to obtain a FSBS. The resident's FSBS was 234. LPN #2 dialed the Lantus insulin pen to 25 units and drew 6 units of aspart insulin. LPN #2 verified the insulins with LPN #1, then handed both syringes to LPN #1. LPN #1 administered both insulins to Resident #27. On 02/05/25 at 11:11 a.m., LPN #2 stated they had drawn the insulin and gave the syringes to LPN #1 to administer. On 02/05/25 at 11:14 a.m., LPN #1 stated LPN #2 had drawn the insulin into the syringes and handed the syringes to them. They stated the person preparing the insulin should be the one to administer the insulin. On 02/05/25 at 11:16 a.m., LPN #1 stated policy had not been followed. On 02/05/25 at 11:19 a.m., the DON reviewed the policy and stated the policy was not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375144	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Creek Skilled Nursing & Therapy	2300 Iowa Avenue Chickasha, OK 73023

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 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. 49701 Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered for 1 (#30) of 18 sampled residents reviewed for following physician orders. The administrator reported 76 residents resided in the facility. Findings: Resident #30 had diagnoses which include chronic obstructive pulmonary disease and congestive heart failure. A physician's order, dated 12/03/24, showed the resident was to receive oxygen at 2 liters per nasal cannula every day and night shift related to chronic obstructive pulmonary disease with acute exacerbation. On 02/06/25 at 9:57 a.m., the DON stated, If there is an order for oxygen, then it is the responsibility of the assigned nursing staff to keep the oxygen on the resident. On 02/03/25 at 1:36 p.m., Resident #30 was observed with their oxygen tank set to 2.5 liters per nasal cannula. The oxygen tubing was in the bag attached to the oxygen concentrator and not on the resident. On 02/03/25 at 1:40 p.m., advanced certified medication aide #2 stated they did not know if Resident #30 was supposed to wear their oxygen all of the time, but they would check with the nurse. On 02/03/25 at 1:43 p.m., LPN #2 stated it was supposed to be on, but it was not. They then put the oxygen on the resident and checked their oxygen saturation which was 93%. LPN #2 stated Resident #30 was up in their wheelchair earlier and they must have forgot to switch it over.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375144	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Creek Skilled Nursing & Therapy	2300 Iowa Avenue Chickasha, OK 73023

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 49701 Based on record review and interview, the facility failed to ensure a resident who received an anticoagulant medication had an acceptable diagnosis/indication for the use of the medication for 1 (#56) of 5 sampled residents reviewed for unnecessary medications. The administrator identified 76 residents who resided in the facility. Findings: Resident #56 had diagnoses which included anxiety, displaced closed fracture of left femur from 2023, and mild cognitive impairment. A physician's order, initiated 09/27/23, showed to give Eliquis (an anticoagulant) 2.5 milligram tablet by mouth twice daily related to displaced closed fracture of the left femur (this diagnosis was from 2023 and was never updated). On 02/05/25 at 12:08 p.m., the ADON stated a displaced closed fracture of the left femur was no longer an appropriate diagnosis for Eliquis to continue to be given. On 02/05/25 at 12:12 p.m., the DON stated checking the accuracy of diagnoses was a group job. They stated a displaced fracture from 2023 was not an appropriate diagnosis for Eliquis.