STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375158	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Timbers Skilled Nursing and Therapy	2520 South Rankin Edmond, OK 73013

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 - Immediate jeopardy to resident health or safety 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. On 02/26/26, an IJ situation was determined to exist related to the facility's failure to ensure the physician was notified of a resident's low blood sugar. On 11/27/24 at 8:00 p.m., Resident #129's blood sugar was 64 and the resident was administered 40 units of long-acting insulin (Toujeo SoloStar subcutaneous solution). Resident #129's physician was not notified of the low blood sugar as required by their order. On 11/28/24 at 9:07 a.m., Resident #129 was assessed to be unresponsive and 911 was called and emergency services arrived and reported Resident #129's blood sugar was 41. On 02/26/26 at 3:43 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 02/26/26 at 5:14 p.m., the administrator was notified of the IJ situation and provided the IJ template.On 02/27/26 at 10:56 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. Plan of Removal Request:a. How facility will ensure harm will not occur or recur;In-service all licensed nursing staff on signs and symptoms of hypoglycemia and when to notify physician. DON and/or designee. In service was done in person and phone with staff acknowledgment and verbalize understanding of parameters and when to notify physician on change of condition for hypoglycemia Residents. Completed 2/26/2026 @2020Audit all residents with hypoglycemia parameters ensuring notification order is in place. DON and/or designee.Completed - 2/26/2026 @ 2210Monitoring orders will be added for appropriate residents for signs and symptoms of hypoglycemia with notification order attached. DON and/or designee.Completed - 2/26/2026 @ 2210Parameter and notification orders placed instructed by Medical director for all residents with hypoglycemia below 70 and notify. Completed - 2/26/2026 @ 2210 b. Date of implementation - planned implementation (actions do not need fully resolved prior to the survey team exiting the organization);2/26/2026c. Identify those residents who have suffered or are likely to suffer, a serious adverse outcome as a result of the noncompliance; andResidents identified and monitoring orders with appropriate parameters to notify physicians. 2/26/2026 DON and/or designee d. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.In-service all licensed nursing staff regarding prompt physician notification of change in condition/hypoglycemia. DON and/or designee 2/26/2026Review of all residents with hypoglycemia or diabetes ensure parameters are in place for notifying physician. DON and/or designee 2/26/2026 The likelihood for serious harm to any resident no longer exists effective 2/26/2026e. How are you addressing assessment, intervention, documentation, and evaluation?Root Cause analysis of the eventCompleted 2/26/2026Audit residents 2/26/2026 with diagnosis of hypoglycemia and/or diabetes ensuring parameters are in place to notify physician. DON and/or designee.The date of substantial compliance: 02/26/26.The IJ was lifted on 02/27/26 at 12:11 p.m., when all components of the plan of removal had been confirmed to have been completed. In-services and orders were reviewed, and staff were interviewed regarding hypoglycemic residents. The deficiency remained at an isolated level with the potential for than minimal harm. Based on record (continued on next page)

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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	review and interview, the facility failed to ensure a physician was notified of a change in condition for hypoglycemia for 1(#129) of 4 sampled residents reviewed for changes in condition.The administrator identified 120 residents resided in the facility.The DON identified 25 residents received insulin in the facility. Findings:A facility policy titled Notification of Change, dated 07/2012, read in part, The facility will notify the resident, the resident's physician and the resident's representative (if applicable) promptly when there is: 1.A significant change in the residents' physical, mental or psychological status,2. An accident involving the resident that results in injury or has the potential for requiring physician intervention,3. A need to alter treatment significantly, and4. A decision to transfer or discharge the resident from the facility.An admission MDS for Resident #129, dated 11/24/24, showed the resident had a BIMS score of 10 which indicated moderate cognitive impairment and they received insulin injections.A Baseline Assessment and Care Plan for Resident #129, dated 11/18/24, showed the resident had diagnoses which included type 2 diabetes mellitus with hyperglycemia.A physician's order for Resident #129, date ordered 11/18/24, showed Glucagon Emergency Injection Kit 1 mg (a medication to treat very low blood sugar), inject one dose intramuscularly (a shot into a muscle) as needed for FSBS less than 71, give cola/orange juice and/or high carb snack, and notify physician.A document titled Injections/Insulin/FSBS for Resident #129, dated 11/27/24 at 8:00 p.m., showed the resident's blood sugar was 64. The physician was not notified of the FSBS below 71 per physician's order.A Nurses Progress Note for Resident #129, dated 11/28/24 at 9:07 a.m., read in part, Focused assessment r/t need for send out for emergency services. Upon assessment it was noted pt was unresponsive. Pt not even reacting to sternal rub. VS obtained 130/73, 78, 96%, 12, 97.8. This nurse called 911, EMS arriving and reporting FSBS was 41. Pt then transported via stretcher to [hospital name withheld].A facility policy titled Blood Glucose Monitoring Guideline, dated 01/2026, read in part, Follow physician orders based on finger stick results. If no follow up orders are in place, notify the physician of noted signs/symptoms of hypo/hyperglycemia.A document titled Quality Assurance and Performance Improvement, dated 02/26/26, showed the facility held a QA meeting to discuss and implement measures related to the failure of notification to physician.An in-service document, dated 02/26/26, showed all staff had been educated on physician and family notifications of changes, what constituted a change in condition, and how a change in condition would be communicated internally.On 02/26/26 at 2:14 p.m., RN #2 stated if a diabetic resident was unresponsive, they called 911 and notified the physician and family.On 02/26/26 at 2:22p.m., RN #1 stated if a diabetic resident was unresponsive, they checked a FSBS and notified the physician. On 02/26/26 at 2:50 p.m., the DON stated if there were orders to notify the physician of blood sugar less than 71, they expected the nurses to follow the order and notify the physician.On 02/26/26 at 2:53p.m., RN#1 was shown the November 2024 Injection/Insulin/FSBS administration record. They stated their initials indicated the blood sugar was 64. RN #1 stated they did not call the physician per orders.On 02/27/26 at 10:02 a.m., the medical Director stated if a resident blood sugar was below 71 nurses should notify the physician.On 02/27/26 at 11:12 a.m., RN #2 stated they were educated on identifying changes in condition for residents. They stated they were educated on notifying physicians and representatives of changes in condition. On 02/27/26 at 11:15 a.m., LPN #1 stated they assisted in providing education for all staff regarding changes in condition for residents. They stated they were a part of the quality assurance meeting.On 02/27/26 at 11:16 a.m., LPN #2 stated they were educated on signs and symptoms of hypoglycemia, identifying changes in condition in residents, and when to notify the physiciany of changes.On 02/27/26 at 11:17 a.m., LPN #3 stated they were educated on changes in condition and when to notify the physician of changes.02/27/26 at 11:20 a.m., the assistant director of nursing stated (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they were educated on notifications to the physician regarding changes in condition.On 02/27/26 at 11:22 a.m., LPN #4 stated they were educated on identifying changes in condition for residents. They stated they were educated on when to notify the physician and resident's representative regarding changes in condition.

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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 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. On 02/26/26, an IJ situation was determined to exist related to the facility's failure to have a system in place to ensure residents with low blood sugar received treatments as ordered by a physician. On 11/27/24 at 8:00 p.m., Resident #129 was found to have a FSBS of 64 and was not given their ordered glucagon, the resident's physician was not notified of the low blood sugar as required by their order. RN #2 then administered 40 units of a long-acting insulin [Toujeo SoloStar subcutaneous solution] to Resident #129. On 11/28/24 at 09:07 a.m., Resident #129 was assessed to be unresponsive and 911 arrived and reported resident #129 blood sugar was 41. On 02/26/26 at 3:43p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 02/26/26 at 5:15 p.m., the Administrator was notified of the IJ situation and provided the IJ template.On 02/27/26 at 10:56 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health.Plan of Removal Request:a. How facility will ensure harm will not occur or recur;In-service all licensed nursing staff on signs and symptoms of hypoglycemia and treatment within the physician's orders. DON and/or designee. In service was done in person and phone with staff acknowledgment and verbalize understanding of parameters, treatments, and following physician's orders for hypoglycemia Residents. Completed 2/26/2026 @2020Audit all residents with hypoglycemia or diabetes ensuring Physician treatment orders with parameters are in place. DON and/or designee.Completed - 2/26/2026 @ 2210Monitoring orders will be added for appropriate residents for signs and symptoms of hypoglycemia. DON and/or designee.Completed - 2/26/2026 @ 2210Parameter orders placed instructed by Medical director for all residents with hypoglycemia below 70. Completed - 2/26/2026 @ 2210 b. Date of implementation - planned implementation (actions do not need fully resolved prior to the survey team exiting the organization);2/26/2026c. Identify those residents who have suffered or are likely to suffer, a serious adverse outcome as a result of the noncompliance; andResidents identified and monitoring orders are appropriate for signs and symptoms of hypoglycemia and/or diabetes. DON and/or designee 2/26/2026 d. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.In-service all licensed nursing staff on signs and symptoms of hypoglycemia and treatment. DON and/or designee 2/26/2026Review of all residents with hypoglycemia or diabetes ensuring all physician orders with parameters are in place. DON and/or designee 2/26/2026Compliance rounds initiated to ensure licensed nursing staff understand signs and symptoms of hypoglycemia and treatment following physician orders. DON and/or designee 2/26/2026The likelihood for serious harm to any resident no longer exists effective 2/26/2026f. How are you addressing assessment, intervention, documentation, and evaluation?Root Cause analysis of the eventCompleted 2/26/2026Audit residents 2/26/2026 with diagnosis of hypoglycemia and/or diabetes ensuring monitory physician orders are in place. By DON and/or designeeThe date of substantial compliance: 2/26/26.On 02/26/26, review of in-service training, review of audits and review of staff competencies, the IJ was lifted on 2/26/26 at 12:11 p.m., when all components of the plan of removal had been confirmed to have been completed. The deficiency remained at an isolated level with the potential for than minimal harm.Based on record review and interview, the facility failed to assess, monitor, and intervene for 1(#129) of 4 residents reviewed for hypoglycemia.The DON identified 25 residents receive insulin in the facility.Findings:A facility document titled Baseline Assessment and Care Plan, dated 11/18/24, showed Resident #129 diagnosis included type 2 diabetes mellitus with hyperglycemia.A facility document titled, Injections/Insulin/FSBS, showed on 11/27/24 at 8:00 p.m., Resident #129 had a blood sugar of 64 and was not given per physician orders Glucagon (a medication to treat very low blood sugar) to inject 1 dose intramuscularly (a shot into a muscle) as (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	needed for FSBS (finger stick blood sugar) less than 71 give cola/orange juice and or high carb snack.A Nurses Progress Note, dated11/28/24, at 9:07 a.m., read in part, Focused assessment r/t need for send out for emergency services. Upon assessment it was noted pt was unresponsive. Pt not even reacting to sternal rub. VS obtained 130/73, 78, 96%, 12, 97.8. This nurse called 911, EMS arriving and reporting FSBS was 41. Pt then transported via stretcher to [hospital name withheld].A facility policy titled Blood Glucose Monitoring Guideline, dated 01/2026, read in part, Follow physician orders based on finger stick results. If no follow up orders are in place, notify the physician of noted signs/symptoms of hypo/hyperglycemia. A facility document titled, Injections/Insulin/FSBS, showed an order for Glucagon Emergency Injection Kit 1mg (a medication to treat very low blood sugar) to inject 1 dose intramuscularly (a shot into a muscle) as needed for FSBS (finger stick blood sugar) less than 71 give cola/orange juice and or high carb snack and notify physician.A document titled Quality Assurance and Performance Improvement, dated 02/26/26, showed the facility held a QA meeting to discuss and implement measures related to the failure to assess, monitor, and intervene for a resident with hypoglycemia.An in-service document, dated 02/26/26, showed all staff had been educated on assessing, monitoring, and intervening for residents with hypoglycemia.On 02/26/26 at 2:14 p.m., RN #2 stated if a diabetic resident was unresponsive, they called 911 and notified the physician and family.On 02/26/26 at 2:22p.m., RN #1 stated a resident with a blood sugar of 64 depending on how responsive the resident is they would give glucose tablets or fluids or a snack. If the resident can swallow, they are not going to give a shot.On 02/26/26 at 2:50 p.m., the DON stated if there were orders to notify the physician of blood sugar less than 71, they expected the nurses to follow the order and notify the physician.On 02/26/26 at 2:53p.m., RN #1 showed the November Injections/Insulin/FSBS administration record with Resident #129 blood sugar of 64. RN #1 stated their initials which indicated they administered 40 units of (Toujeo SoloStar subcutaneous solution) long-acting insulin to Resident #129.On 02/27/26 at 10:02 a.m., Medical Director stated if a resident had a blood sugar of 64 depending on the status of the resident if awake administer juice if unresponsive give Glucagon injection. They stated they would not expect the nurse to administer a long-acting insulin.On 02/27/26 at 11:12 a.m., RN #2 stated they were educated on assessing, monitoring, and intervening for residents with hypoglycemia.On 02/27/26 at 11:15 a.m., LPN #1 stated they assisted in providing education for all staff regarding assessing, monitoring, and intervening for residents with hypoglycemia.On 02/27/26 at 11:16 a.m., LPN #2 stated they were educated on signs and symptoms of hypoglycemia and assessing, monitoring, and intervening for residents with hypoglycemia.On 02/27/26 at 11:17 a.m., LPN #3 stated they were educated on assessing, monitoring, and intervening for residents with hypoglycemia.02/27/26 at 11:20 a.m., the assistant director of nursing stated they were educated on assessing, monitoring, and intervening for residents with hypoglycemia.On 02/27/26 at 11:22 a.m., LPN #4 stated they were educated on assessing, monitoring, and intervening for residents with hypoglycemia.