

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER The Timbers Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>45462</p> <p>Based on observation and interview, the facility failed to ensure staffing information was posted with the required components and was accessible to all residents.</p> <p>The Administrator identified 118 residents resided in the facility.</p> <p>Findings:</p> <p>On 06/17/24 from 8:20 a.m. through 06/20/24 at 8:15 a.m., this surveyor observed there was no staffing information posted with the required components and accessible to residents and visitors.</p> <p>On 06/20/24 at 9:00 a.m., Corp. Nurse Consultant #1 was asked where the facility daily staffing was posted. They stated it was in the binder at the nurses station. When asked if it was posted on the wall somewhere with the required components and accessible to residents and visitors. The Corp. Nurse Consultant acknowledged it was not.</p>

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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