

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER The Springs Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 5800 West Okmulgee Muskogee, OK 74401	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a conveyance of funds within 30 days of death for 1 (#101) of 2 sampled residents reviewed for personal funds. The BOM identified 32 residents in the facility trust account. Findings: An undated policy titled Resident Trust Policies and Procedures - Nursing Facilities, read in part, A discharged or expired resident's trust account should be closed within 30-60 days. (30 days per Oklahoma State guidelines) A Trust-Transaction History form, dated [DATE] through [DATE], showed Resident #101 had a remaining balance of \$920.09 in the facility trust account. A nurse note, dated [DATE], showed Resident #101 had been sent to the emergency room for evaluation. A nurse note, dated [DATE], showed two family members had come to the facility and gathered Resident #101's personal belongings. A letter on facility letter head, to the SSA, dated [DATE], showed the facility inquired about a check which had been applied to the trust account for Resident #101 on [DATE], and the resident had expired on [DATE] at the hospital. A Trust Statement, dated [DATE], showed Resident #101 had a closing balance of \$1,282.09. A Social Security Administration [NAME] Statement, dated [DATE], showed an overpayment of benefits had been paid to Resident #101. The billing statement showed a balance of \$362.00 was due by [DATE]. A Trust Statement, dated [DATE], showed Resident #101 had a closing balance of \$1,282.09. An Activity Report, dated [DATE], showed a call had been placed to the SSA by the BOM. The representative for the SSA informed them to return the funds dated [DATE]. A Social Security Administration Electronic Payment Reminder, dated [DATE], showed a payment of \$362.00 was due to be paid back to the SSA. A letter on facility letter head, to the Social Security Administration, dated [DATE], showed a check for \$362.00 had been made payable to the SSA. A Transfer/Discharge Report, dated [DATE], showed Resident #101 had a diagnosis of dementia and was discharged from the facility on [DATE]. On [DATE] at 9:05 a.m., the BOM stated they had attempted to find out about overpayment from the SSA for Resident #101. They stated they would look for their documentation regarding conversations with the SSA and the family of Resident #101. On [DATE] at 4:22 p.m., the BOM stated they had made calls with the SSA between [DATE] and [DATE] but did not have documentation of the calls. They stated they would need to convey funds to the resident's family. On [DATE] at 4:33 p.m., the administrator stated funds were typically conveyed within 30 days of death by the home office. They stated the BOM had attempted to work out the overpayment from the SSA, but did not have documentation.</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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to secure cleaning chemicals in 1 of 1 shower rooms on the 400 hall. The nurse consultant identified one shower room on the 400 hall. Findings: On 09/17/25 at 9:10 a.m., the 400 hall shower room door was observed ajar. No residents were observed wandering on the 400 hall. The 400 hall shower room was unsecured and unattended. The door handle locked automatically, had a passcode lock for entry, and the door spring tension was adequate to pull the door closed. Upon entering the shower room, an opaque spray bottle was observed hanging from the whirlpool lift. The spray bottle contained a clear liquid and was labelled with QUAT STAT 5 (disinfectant) in permanent marker. On 09/17/25 at 2:30 p.m., the 400 hall shower room door was observed ajar. No residents were observed wandering on the 400 hall. The 400 hall shower room was unsecured and unattended. The door handle locked automatically, had a passcode lock for entry, and the door spring tension was adequate to pull the door closed. Upon entering the shower room, an opaque spray bottle was observed hanging from the whirlpool lift. The spray bottle contained a clear liquid and was labelled with QUAT STAT 5 in permanent marker. A safety data sheet for QUAT-STAT 5, dated 02/04/21, read in part, Signal word: Danger. Hazard statements: Combustible liquid. Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage. Storage: Store locked up. Store in a well-ventilated place. Keep cool. On 09/23/25 at 4:45 p.m., the DON stated chemicals were to be stored locked away where residents could not access them. On 09/24/25 at 5:42 p.m., the administrator stated the last safety check performed was in August. The administrator stated chemicals were to be secured away from residents. The administrator stated if the shower room door was closed, the chemical would have been secured.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on record review and interview, the facility failed to ensure weights were obtained as ordered by the physician for 1 (#52) of 4 sampled residents reviewed for nutrition. The administrator identified 86 residents resided in the facility. Findings: A physician order, dated 02/05/25, showed Resident #52 was to be weighed monthly. Review of the weights in the electronic health record, dated 03/01/25 through 09/17/25, showed the last weight obtained was dated 06/10/25. The electronic health record did not show a weight had been obtained in July 2025 or August 2025. A quarterly assessment, dated 09/19/25, showed Resident #52 had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of depression. A care plan, updated 09/22/25, showed Resident #52 was at risk for weight fluctuations. The care plan, read in part, weigh per physician orders/facility protocol. On 09/24/25 at 9:49 a.m., LPN #1 stated the nurses and CNAs were responsible to obtain resident weights and document in the electronic clinical record. LPN #1 reviewed the electronic clinical record and stated they did not know why a weight for Resident #52 had not been obtained in July 2025 or August 2025. On 09/24/25 at 9:54 a.m., the DON stated the MDS coordinator provided a list of residents to the nurse for the CNA to obtain weights. The DON stated it was the MDS coordinator's responsibility to ensure weights were obtained per physician orders. They stated the MDS coordinator was new to the position. They stated Resident #52 likely refused to be weighed in July 2025 and August 2025 and there should have been a progress note made if the resident refused. On 09/24/25 at 10:46 a.m., the DON stated they followed the physician orders regarding weights. The DON stated they had reviewed the electronic clinical record and did not find documentation of weights or the resident refusing weights in July 2025 or August 2025.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to ensure food was served in accordance with professional standards for food service safety for 1 of 1 meal service observed. The administrator identified 86 residents ate meals prepared in the kitchen. Findings: On 09/18/25 at 11:57 a.m., the cook was observed obtaining food temperatures for the lunch meal. The chicken patty was 192 degrees Fahrenheit, and the ground chicken patty was 141 degrees Fahrenheit. On 09/18/25 at 12:16 p.m., the dietary aide was observed tempting food in the main bistro dining area. The chicken patty was 95.6 degrees Fahrenheit. On 09/18/25 at 1:38 p.m., the dietary aide stated the steam table was turned on every morning around 6:00 a.m. and it remained on until dinner was served. They stated food was tempted before it left the main kitchen and transferred into a hot box to the bistro. They stated food was then placed onto the steam table and the temperature should be recorded again. The dietary aide stated they should take the food back to the main kitchen to be reheated if the food was not at the desired temperature. The dietary aide stated the chicken patty should be at least 130 degrees. When asked if they knew what the problem was with the significant drop in temperature the dietary aide stated it may be due to the food not being covered while serving. On 09/18/25 at 1:50 p.m., the dietary manager stated the significant change in temperature could be due to the food not being covered while serving. They stated the dietary aide should have brought the food back to the main kitchen. They dietary manager stated they did not have a facility policy on maintaining warm foods. They stated their own personal policy was to temp the food before, during, and after serving.</p>		