STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to securely store medicated creams for 1 of 1 treatment carts located on the 400 hall and failed to label an open date on a multi-dose vial of tuberculin protein derivative used to check residents and facility staff for the possible presence of the tuberculin virus and stored in the 300/400 medication room. The DON identified three medication rooms and three treatment carts in the facility. Findings: On 09/17/25 at 11:58 a.m., the 400 hall treatment cart was observed unlocked and unattended. The treatment cart contained lidocaine 2.5%/Prilocaine 2.5% medicated cream, cadexomer lodine gel (antimicrobial gel to clean wounds), Vashe wound solution, Santyl cream (topical medicine), mupirocin ointment (topical medicine), and coloplast cream (moisture barrier). On 09/23/2025 at 3:38 p.m., the 300/400 hall medication room was observed with RN #1. An open multi-dose vial of tuberculin protein derivative was observed in the refrigerator bin. There was no open date observed on the vial and no box present for the multi-dose vial. On 09/23/25 at 3:38 p.m., the open multi-dose vial of tuberculin protein derivative showed to discard the vial 30 days after opening. On 09/23/25 at 3:39 p.m., RN #1 stated the multi-dose vial of tuberculin protein derivative did not have a documented open date. RN #1 stated the multi-dose vial read to discard the vial 30 days after it was opened. On 09/23/25 at 4:45 p.m., the DON stated if the vial was opened, it had to have a date it was opened. The DON stated tuberculin protein derivative was to be discarded 30 days after it was opened. The DON stated medication carts and treatment carts were to be locked before stepping away from the cart and were not to be left unattended and unsecured.

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
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure a discharge summary with a recapitulation of the resident's stay was completed for 1 (#99) of 1 sampled resident reviewed for discharge.The BOM identified 27 residents discharged in the past 30 days.Findings: A care plan, dated 06/30/25, showed Resident #99 had a diagnosis of congestive heart failure and planned to return to the community with family. An admission assessment, dated 07/06/25, showed Resident #99 had a BIMS score of 13, which indicated the resident's cognition was intact, and planned to return to the community upon discharge. A physician order, dated 07/29/25, showed Resident #99 was discharging with home health on 07/30/25. A progress note, dated 07/30/25, showed Resident #99 discharged home with family with home health services. On 09/24/25 at 1:13 p.m., the DON stated usually the MDS coordinators completed discharge summaries. They stated a discharge summary with a recapitulation of the resident's stay had not been completed for Resident #99's planned discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure level 2 PASARR recommendations were incorporated into the plan of care for 1 (#11) of 1 sampled resident reviewed for PASARR.The BOM identified four residents had a level 2 PASARR.Findings: Review of the scanned documents in the electronic clinical record, dated 01/01/25 - 09/01/25, showed Resident #11 had been seen by psychiatric services on 03/01/25, 04/09/25, 07/09/25, and 08/13/25. A progress note, dated 01/17/25 at 11:21 a.m., showed a PASARR meeting had been completed for Resident #11. A PASRR-MI [mental illness] Summary of Findings, dated 01/18/25, showed recommendations for psychiatric follow up services monthly and individual counseling/psychotherapy 45 minutes a week minimum to be provided by a licensed mental health provider. A significant change assessment, dated 08/19/25, showed Resident #11 had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making, and had diagnoses of depression and psychotic disorder other than schizophrenia. A care plan, updated 09/08/25, showed Resident #11 had a mood disorder with visual hallucinations and psychiatric services was to evaluate and treat as indicated. A review of Resident #11's electronic clinical record did not show a level 2 PASARR. On 09/24/25 at 12:10 p.m., the administrator stated they had to call to get a copy of the level 2 PASARR for Resident #11 because they did not have it in the facility or in the electronic clinical record. They stated the corporate quality manager nurse had requested the level 2 PASARR. On 09/24/25 at 12:13 p.m., quality manager nurse #1 stated they had not received the level 2 PASSAR for Resident #11. They stated it was the BOM or their responsibility to obtain the results of the level 2 PASSAR for implementation of the recommendations. On 09/24/25 at 2:56 p.m., the care plan coordinator stated the level 2 PASSAR recommendations had not been implemented onto the care plan because it had just been received earlier on this day. On 09/24/25 at 2:58 p.m., the administrator stated they were unaware they had not had the level 2 PASSAR summary to implement the recommendations until earlier on this day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a written summary of the baseline care plan to the resident/resident representative for 1 (#30) of 2 residents sampled for the development, implementation, and dissemination of the baseline care plan to the resident/resident representative.The administrator identified 86 residents resided in the facility. Findings: A baseline care plan, dated 11/15/24, showed Resident #30 was admitted on [DATE]. The baseline care plan showed a copy of the admission orders were given to the resident/resident representative other and listed the resident's contact representative as the resident's caregiver and emergency contact. There was no documentation the resident/resident representative received a summary of the baseline assessment/care plan or a copy of the medication administration record or treatment record. On 09/22/25 at 4:22 p.m., the MDS coordinator reviewed the resident's clinical record and stated they did not see documentation the resident or resident representative were given a copy of the baseline care plan. On 09/24/25 at 4:20 p.m., the DON reviewed the baseline care plan and the resident's clinical record and stated there was no documentation the resident or resident representative were given a copy of the baseline care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to ensure the care plan had been revised to include the use of bed rails for 1 (#11) of 1 sampled resident reviewed for bed rails.Quality Manager Nurse #2 identified 25 residents utilized bed rails. Findings:On 09/17/25 at 10:46 a.m., a bed rail was observed on the right side of Resident #11's bed in the up position.A significant change assessment, dated 08/19/25, showed Resident #11 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 09/08/25, did not show the Resident #11 utilized a bed rail to the right side of the bed.On 09/24/25 at 2:32 p.m., quality manager nurse #2 reviewed the care plan for Resident #11 and stated since they utilized a bed rail, the care plan should have been revised. On 09/24/25 at 2:56 p.m., the MDS coordinator stated they had reviewed the care plan and the bed rail had not been addressed. On 09/24/25 at 3:45 p.m., the DON stated Resident #11 had utilized a bed rail for approximately 1.5 years. They stated the bed rail had not been included in the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review and interview, the facility failed to perform post dialysis assessments for 1 (#94) of 1 resident sampled for dialysis care. The nurse consultant identified two dialysis residents residing in the facility. Findings: On 09/17/25 at 11:30 a.m., the right chest wall of Resident #94 was observed to have a dialysis port with a clean and dry dressing covering the port site and distal ends of the port. The August 2025 treatment sheet showed the following for Resident #94:a. dialysis ordered every Tuesday, Thursday, and Saturday;b. orders to weigh the resident on dialysis days;c. the resident's arteriovenous fistula (for dialysis) was to be assessed for thrill/bruit every shift;d. assessed for signs of trauma or infection every shift;e. no blood pressure, labs, or lifting with the arm containing the arteriovenous fistula;f. dialysis port site was to be assessed for trauma and/or infection every shift and;g. no lab drawn, blood pressure, or lifting in the right arm due to the presence of the dialysis port on the right side of the resident's chest wall. The September 2025 treatment sheet, dated 09/01/25 to 09/22/25, did not show the following for Resident #94:a. dialysis was ordered/scheduled;b. an order to weigh the resident on dialysis days;c. the arteriovenous fistula was assessed for thrill/bruit, signs of trauma, or infection;d. not to perform blood pressure, lab draws, or lifting with the arm containing the arteriovenous fistula;e. to assess the resident's dialysis port for signs of trauma/infection; andf. not to obtain blood pressure, lab draws, or lifting in the right arm due to the presence of the dialysis port on the right side of the resident's chest wall. On 09/22/25 at 4:42 p.m., the MDS coordinator stated they worked as the floor nurse on 400 hall until recently. The floor nurse documented the pre dialysis assessment on a form and sent a copy of the form to dialysis with the resident. The MDS coordinator stated when the resident returned from dialysis, the nurse received the form and typed the written information into the resident's electronic medical record that the dialysis center provided. The MDS coordinator stated the post dialysis vital signs typed into the pre/post dialysis assessment were obtained by the dialysis provider prior to the resident returning to the facility and did not automatically populate in the resident's electronic medical record. The MDS coordinator stated the post dialysis assessment was documented on the treatment record. The MDS coordinator reviewed the resident's clinical record and stated they did not see where the facility staff assessed the resident post dialysis but would consult with the director of nurses. On 09/23/25 at 10:50 a.m., the MDS coordinator stated they consulted with the DON and resumed all the previous dialysis orders. The MDS coordinator stated the resident was hospitalized at the end of August and when the resident returned to the facility, the admitting nurse failed to resume the orders related to dialysis. On 09/24/25 at 4:20 p.m., the DON stated when Resident #94 was re-admitted to the facility at the end of August, the admitting nurse failed to resume orders related to dialysis. The DON stated the staff knew to perform the pre/post assessment, but failed to tell anyone the orders were not in place to document their findings. The DON stated the nurse documented the pre dialysis assessment on the dialysis assessment form, but the form did not have space for the facility's post assessment, and they should have documented the post assessment in the progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, record review, and interview, the facility failed to ensure an assessment for the use of bed rails had been completed for 1 (#11) of 1 sampled resident reviewed for bed rails.Quality Manager Nurse #2 identified 25 residents utilized bed rails. Findings:On 09/17/25 at 10:46 a.m., a bed rail was observed on the right side of Resident #11's bed in the up position.A significant change assessment, dated 08/19/25, showed Resident #11 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 09/08/25, did not show Resident #11 utilized a bed rail to the right side of the bed.Review of the electronic clinical record, dated 09/01/24 through 09/24/25, did not show Resident #11 had been assessed for the use of bed rails or consent had been obtained.On 09/24/25 at 2:12 p.m., quality manager nurse #2 stated they did not have a policy for the use of bed rails, but they were to complete an assessment, obtain consent, obtain a physician order, update the care plan and document a progress note. On 09/24/25 at 2:32 p.m., quality manager nurse #2 stated they had not completed an assessment, obtained consent or obtained a physician order for the use of bed rails for Resident #11. On 09/24/25 at 3:45 p.m., the DON stated Resident #11 had utilized a bed rail for approximately 1.5 years. They stated they had reviewed the electronic clinical record and it did not show an assessment had been completed, a physician order, or a consent had been obtained for the use of the bed rail.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Skilled Nursing and Therapy	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)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview, the facility failed to ensure regular inspection of bed rails as part of their maintenance program for 1 (#11) of 1 sampled resident reviewed for bed rails.Quality Manager Nurse #2 identified 25 residents utilized bed rails. Findings:On 09/17/25 at 10:46 a.m., a bed rail was observed on the right side of Resident #11's bed in the up position.A significant change assessment, dated 08/19/25, showed Resident #11 had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of depression.On 09/24/25 at 3:04 p.m., the maintenance supervisor stated they applied bed rails to beds as indicated by the DON, but they did not regularly inspect them after installation. On 09/24/25 at 3:11 p.m., the administrator stated they did not have a policy related to bed rails, bed safety, or inspection of resident beds. They stated maintenance installed bed rails, but did not regularly inspect them as part of the maintenance program. The administrator stated Resident #11 had an enabler bar and they did not consider enabler bars to be bed rails. On 09/24/25 at 3:33 p.m., the administrator stated if they had put an order in for the use of bed rails for Resident #11 the nursing staff would have monitored every shift to ensure the bed rails were in place. On 09/24/25 at 3:45 p.m., the DON stated Resident #11 had utilized a bed rail for approximately 1.5 years.