STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375165	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broken Bow Nursing Home	700 West Jones Broken Bow, OK 74728

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a care plan was updated for 1 (#1) of 3 sampled residents reviewed for care plan.The DON reported 61 residents resided in the facility.Findings:A facility policy titled Care Plan, Comprehensive Person-Centered, dated December 2016, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .13. Assessments of resident are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition;A physician consultation note for Resident #1, dated 03/24/25, read in part, Principal Diagnosis: Breast Cancer.A care plan for Resident #1, dated 05/27/25, showed no interventions or diagnosis for cancer was updated on the most recent care plan.On 08/21/25 at 10:51 a.m., the ADON reviewed Resident #1's most recent care plan, dated 05/27/25. They stated Resident #1 had no cancer diagnosis or interventions.On 08/21/25 at 11:16 a.m., the DON stated according to policy Resident #1's care plan should have been updated with interventions and a cancer diagnosis.

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
	375165	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broken Bow Nursing Home	700 West Jones Broken Bow, OK 74728

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375165	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broken Bow Nursing Home	700 West Jones Broken Bow, OK 74728

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/21/25, an IJ situation was determined to exist related to the facilities failure to provide pharmacy services for Resident #1 in a timely manner.The facility was notified on 08/21/25 at 5:30 p.m., the Oklahoma State Department of Health was notified of the existence of an Immediate Jeopardy situation. On 08/21/25 at 5:38 p.m., the DON and administrator were notified of the existence of an IJ situation related to pharmacy services for Resident #1 . The IJ template was provided to administrator.On 08/23/25 at 9:26 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Removal of Immediate Jeopardy StatementFacility Name: Broken Bow Health And Rehab Date IJ Identified: August 21, 2025 Resident Affected: Resident #1Actions Taken to Remove the Immediate JeopardyUpon discovery, the facility immediately implemented the following corrective actions to mitigate risk and remove the Immediate Jeopardy:Resident-Centered Interventions-Resident #1 continues on current medication regiment with current cancer treatment.-Resident #1's care plan is updated with the Cancer diagnosis and treatment.-Care Plan meeting is scheduled on 8/22/25 with Resident #1, POA, and Hospice to discuss plan for further follow-up and treatment for the breast cancer.-The Pharmacy Consultant will review Resident #1's chart on 8/22/25 to determine any discrepancy that may need intervention by PCP. Systemic Corrective Measures ImplementedTo prevent recurrence of this type of error, the following systemic interventions were implemented:- Change of Pharmacy was initiated on February 17th, to be electronic and less dependent on fax to reduce opportunity for errors, and if any errors are discovered it will be corrected immediately.-During daily standup and 24 hour report review which contains all new orders; will be reviewed to ensure medications have been ordered and are in the facility. If not, it will be immediately be addressed and corrected.- QA meeting will be held 8/22/25 reviewing system break downs with the missed medication and Diagnosis.Education & Competency- No Registered Nurses, Licensed Nurses, and Certified Medication will work until they are in-serviced. Starting immediately Registered Nurses, Licensed Nurses, and Certified Medication Aides will be in-serviced on the following items:Med Administration policy & procedureTimeliness of implementation of orderNoting orders and transfer to MARAny conflicts of order must contact PCP for clarificationsIf medications are delivered with no orders they are to be reported to DON or ADON asap to ensure appropriate intervention- All Licensed Nursing staff will be in-serviced on responsible party notification and PCP notifications of med changes from outside consultants policy and procedure.- The [NAME] President of Clinical/CEO will in-service DON and ADON will be on clinical morning meeting routine policy; reviewing 24 hour report to catch items that need to be followed up on.All full-time staff will be in-serviced by the end of 8/22/25, and all P.R.N staff will be in-serviced before to being utilized as needed.On 08/26/25 at 11:27 a.m., after interviews with the facility staff, review of in-services, care plans, medication regimen reviews, medication administration records, and pharmacy consultant sheets. The immediacy was lifted and effective 08/26/25 at 12:10 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to provide pharmacy services in a timely manner for 1 (#1) of 3 resident reviewed for pharmacy services.The DON reported 61 residents resided in the facility.Findings:A minimum date set, dated 03/08/25, read in part, BIMS Score 06.A physician order, dated 03/24/25, read in part, Anastrozole 1 mg tablet, 1mg orally daily.A nursing note, dated 03/26/25, read in part, 03/24/25 Progress notes from doctor at oncology faxed to clinic at this time.A MAR, dated 03/01/25 through 03/31/25, did not show the medication had been administered.A MAR, dated 04/01/25 through 04/30/25, did not show the medication had been administered.A facility policy titled Pharmacy Services Overview, dated 04/2025, read in part, 2. The facility shall contract with a licensed consultant pharmacist to help obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. A medication order sheet, dated 04/2025, read in part, date received: 04/28/25 Anastrozole 1 mg rx# 1563586, amount received 30, received by CMA #1.A nursing note, dated 04/30/25, showed, read in part, concerning Resident #1 oncology apt they called and spoke with the POA and they said cancel appointment due to not receiving the medication oncologist was supposed to put Resident #1 on the first time they seen the doctor .The nurse said the oncologist had sent the script to pharmacy back then.A medication order sheet, dated 04/2025, showed, read in part, date received: 04/28/25 Anastrozole 1 mg rx# 1563586, amount received 30, received by CMA #1.A MAR, dated 05/01/25 through 05/31/25, showed the cancer medication was administered daily from 05/26/25 through 05/31/25. Resident #1 did not receive 77 doses of the cancer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375165	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broken Bow Nursing Home	700 West Jones Broken Bow, OK 74728

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, record review, and interview, the facility failed to ensure 3 (#1, #2 and #3) of 3 sampled treatment carts were locked.The DON reported 61 residents resided in the facility.Findings:On 08/19/25 at 2:26 p.m., treatment cart #1 was observed to be on the left side of the nurse's station unlocked and unsupervised.On 08/19/25 at 2:27 p.m., treatment cart #2 was observed to be on the right side of the nurse's station unlocked and unsupervised.On 08/19/25 at 2:28 p.m., treatment cart #3 (wound care cart) was observed to be at the front entrance by the ADON office unlocked.A facility policy titled Security of Medication Cart, revised 04/2007, read in part, 1. The nurse must secure the medication cart during pass to prevent unauthorized entry .4. Medication carts must be securely locked at all times when out of the nurse's view .5. When the medication cart is not being used, it must be locked and parked.On 08/19/25 at 2:25 p.m. LPN #2 was observed walking away from the unlocked treatment cart. They walked into a medication supply closet and closed the door. There were no other staff observed in the area.On 08/19/25 at 2:29 p.m., the ADON was asked about treatment carts being unlocked. They stated, According to policy, all the carts are to be locked and supervised.On 08/19/25 at 3:21 p.m., LPN #2 stated they went to go get medication cups out of the medication room. The treatments carts were supposed to be locked and supervised.On 08/26/25 at 12:31 p.m., the DON stated they had no wanderers in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375165	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broken Bow Nursing Home	700 West Jones Broken Bow, OK 74728

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and interview, the facility failed to ensure a resident who missed 77 cancer medications was included quality assurance and program improvement for 1 (#1) of 3 sampled residents reviewed for medication administration.The DON reported 61 residents resided in the facility.Findings:A facility policy titled Quality Assurance and Performance Improvement, revised 02/2020, read in part, This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents . f. monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed . Coordination 2. The QAPI coordinator assists other committees, individuals, departments, and/or services in developing quality indicators, monitoring tools, assessments methodologies and documentation, and in making adjustments to plan.On 08/19/25 at 11:19 a.m., the ADON stated how could they QAPI for the cancer medication we did not know about.On 08/26/25 at 11:40 a.m., the DON stated our last QAPI meetings were 06/10/25 and 08/08/25 and Resident #1's cancer diagnosis or interventions were not included in the meetings.