

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Stillwater Creek Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 West 10th Street Stillwater, OK 74074	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>47453</p> <p>Based on record review and interview, the facility failed to notify the physician of a resident leaving AMA for 1 (#4) of 1 sampled resident reviewed for leaving the facility AMA.</p> <p>The administrator identified 62 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #4 had diagnoses which included alcohol abuse, other psychoactive abuse with intoxication, chronic heart failure, anxiety, depression, and anemia.</p> <p>A late entry progress note, dated 11/25/24, showed Resident #4 left the facility under the care of their friend and all medications were in the resident's possession.</p> <p>There was no documentation Resident #4's physician was notified the resident left AMA.</p> <p>On 03/04/25 at 4:14 p.m., the administrator was asked if Resident #4's physician was notified the resident left AMA, or if there was any documentation the physician was notified. The administrator stated there was no documentation.</p> <p>On 03/04/25 at 4:20 p.m., corporate nurse consultant #1 was asked if the facility had a policy or procedure for a resident leaving AMA. They stated, No.</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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