

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Woodward Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 429 E Downs Avenue Woodward, OK 73801	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, and interview, the facility failed to ensure sufficient staffing was available:a. to turn and reposition residents at risk for pressure ulcers for 1 (#3); andb. to prevent dependent residents from being taken to the dining room one hour before meals for 1 (#9) of 3 sampled residents reviewed for staffing. The DON identified 15 dependent residents resided in the facility.Findings: 1. On 07/14/26 from 8:49 a.m. to 11:39 a.m., during continuous observation, Resident #3 was observed lying on their right side in bed throughout the observation period. Staff was not observed to check on Resident #3 or reposition the resident during the continuous observation.An admission assessment for Resident #3, dated 06/16/26, showed the resident's cognition was severely impaired with a BIMS score of 0. The assessment showed the resident was at risk for developing pressure ulcers.A care plan for Resident #3, dated 06/12/26, showed the resident was to be turned every two hours, heels offloaded with pillows, and required assistance with turning and repositioning frequently.On 07/16/26 at 12:35 p.m., CNA #4 stated they had set a reminder on their phone to reposition Resident #3 every two hours. CNA #4 stated Resident #3 remained in the same position because they did not have enough time to reposition every two hours while Resident #3 was in bed, as they were the only staff member assigned to that hall.On 07/16/26 at 3:16 p.m., the DON stated it was not acceptable to keep a resident in the same position for more than two hours if they were unable to reposition.2. On 07/14/26 at 10:59 a.m., Resident #9 was observed in the main dining room drinking coffee and tea. The resident was observed without any food.On 07/14/26 at 11:51 a.m., food was served to Resident #9 sitting in the dining room.A significant change assessment for Resident #9, dated 06/12/26, showed the resident's cognition was intact with a BIMS score of 14. The assessment showed Resident #9 was dependent on staff for activities of daily living, which included transfers and use of a manual wheelchair. The assessment showed Resident #9's diagnoses included stroke and hemiplegia.On 07/14/26 at 11:31 a.m., Resident #9 stated I don't like sitting in the dining room for so long; it hurts my butt sitting here waiting on my food.On 07/14/26 at 1:47 p.m., dietary worker #1 stated staff start to bring the residents to the dining room for lunch at 10:30 a.m. They stated lunch was scheduled to be served at 11:30 a.m., so dietary staff would serve residents something to drink.On 07/14/26 at 2:06 p.m., CNA #1 stated they were told to have dependent residents in the dining room at 10:30 a.m. On 07/16/26 at 11:28 a.m., LPN #1 stated residents were taken to the dining room starting at 10:30 a.m. because it took a long time to get dependent residents up when there was only one aide on the hall.On 07/16/26 at 11:34 a.m., the DON stated they had never told staff to get dependent residents up and to the dining room starting at 10:30 a.m. The DON stated staff should get residents up in their wheelchairs and leave them in their room with the call light instead of taking them to the dining room about 10:45 a.m.On 07/16/26 at 12:51 p.m., the administrator stated there was currently one CNA on each hall working, but they could request help (continued on next page)		

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from them or any other nursing staff to assist them as needed. On 07/16/26 at 12:56 p.m., the administrator stated they tried to over-schedule staff on weekends because they had so many staff call-ins. The administrator stated they did not use agency staff to fill in.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to ensure annual nurse aide skill reviews was conducted for 2 (CNA #2 and CNA #3) of 2 nurse aides sampled for employee training review. The administrator identified 35 residents resided in the facility. Findings: 1. CNA #2's employee file showed they had a hire date of 10/16/24. There was no documentation to show CNA #2 had an annual skills review completed in or after 10/2025. 2. CNA #3's employee file showed they had a hire date of 01/08/25. There was no documentation to show CNA #3 had an annual skills review in or after 01/2026. On 07/16/26 at 12:51 p.m., the administrator stated the required annual skills review for CNA #2 and CNA#3 were not conducted.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain an effective pest control program to ensure the facility remained free of pests. The administrator identified 35 residents resided in the facility. Findings: On 07/14/26 at 10:57 a.m., during an observation of the lunch meal service, three flies were observed on the dining table while residents drank coffee. On 07/14/26 at 11:34 a.m., during an observation of the lunch meal service, eight flies landed on top of the steam table while food was being prepared and served from the steam table. On 07/14/26 at 11:36 a.m., during an observation of the lunch meal, there was a blue light hung in the dining room on the wall. On 07/14/26 at 11:56 a.m., during an observation of the lunch meal service, flies were observed landing on residents' plates containing food. On 07/16/26 at 9:57 a.m., during a wound care observation, multiple flies were observed landing on the clean wound care supplies. A policy titled Pest Control, dated 10/2008, read in part, It's the policy of this facility to maintain an effective pest control program so that the facility is free of pest and rodents. On 07/14/26 at 9:45 a.m., the maintenance supervisor stated they had tried fly bait and fly spray and had requested an indoor solution from their supervisor. On 07/15/26 at 11:38 a.m., LPN #1 stated room [ROOM NUMBER] had a lot of flies and that corporate did not allow sticky traps to be hung. LPN #1 stated the facility used the blue lights for the flies. On 07/16/26 at 10:05 a.m., LPN # 2 stated the flies were terrible in the facility.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, record review, and interview, the facility failed to ensure an allegation of physical abuse was reported to the State Agency within the two hour required timeframe for 1 (#3) of 3 sampled residents reviewed for abuse. The administrator identified 35 residents resided in the facility Findings: On 07/14/26 at 1:18p.m., Resident #3 was observed sitting in a wheelchair with four round purple and yellow areas of circular bruising on their left upper arm. A policy titled Resident Abuse, Neglect and Misappropriation of Property, dated 07/2018, read in part, All allegations and incidents of abuse, neglect or misappropriation of residents' property, must be reported to Quality Assurance Performance Improvement committee, appropriate Federal and State Agencies including OSDH and investigated to establish a reasonable conclusion about the validity of the allegation .Immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury. An admission assessment for Resident #3, dated 06/16/26, showed the resident had a BIMS score of 0 which indicated severe impairment in cognition. The assessment showed the use of anticoagulant medication. On 07/14/26 at 1:12 p.m., Resident #3's family member stated on 07/10/26, they showed the DON Resident #3's bruising on the upper left arm. On 07/14/26 at 4:00 p.m., the administrator stated they followed OSDH guidance on reporting abuse. On 07/16/26 at 4:02 p.m., the DON stated Resident #3's family member showed them the bruised area on the resident's left upper arm. The DON stated they both discussed that the bruising appeared to resemble fingerprints and acknowledged that Resident #3 was receiving Eliquis (a blood thinner medication). On 07/16/26 at 5:07 p.m., the administrator stated more than two hours had elapsed between the allegation and sending the initial report to the OSDH.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident received pressure ulcer prevention interventions to include repositioning every two hours for 1 (#3) of 2 sampled residents reviewed for pressure ulcers. The DON identified three residents with pressure ulcers. Findings: On 07/14/26 from 8:49 a.m. to 11:39 a.m. during continuous observation, Resident #3 was observed lying on their right side in bed throughout the observation period. Staff was not observed to check on resident. A policy titled Skin Integrity/ Wound Care, revised 07/2024, read in part, To promote healing of pressure ulcers. Use Proper positioning, transferring, and turning techniques. A Braden Scale for Resident #3, dated 06/10/26, showed: mobility (ability to change and control body position) as very limited, and friction and shear (require moderate to maximum assistance in moving). A care plan for Resident #3, dated 06/12/26, showed an intervention to turn the resident every two hours, offload heels with pillows, and assist with turning and repositioning frequently. An admission assessment for Resident #3, dated 06/16/26, showed an admission date of 06/10/26. The admission assessment showed a BIMS score of 0 which indicated the resident was severely impaired in cognition for daily decision making. The assessment showed the resident was at risk for developing pressure ulcers. A progress note for Resident #3, dated 06/16/26, showed they had a left heel unstageable pressure ulcer that was acquired. A document titled Wound Dynamics, dated 06/16/26, showed Resident #3's wound to the left heel was a stage two. The document showed the wound measured 4 cm in length, 4.2 cm in width, and no measurable depth with an area of 16.8 square cm. A document titled Wound Dynamics, dated 06/23/26, showed Resident #3's wound to the left heel was a stage 2. The document showed the wound measured 4 cm in length, 4.2 cm in width, and no measurable depth with an area of 16.8 square cm. A document titled Wound Dynamics, dated 07/07/26, showed Resident #3's wound to the left heel was a stage two. The document showed the wound measured 4 cm in length, 5 cm in width, and no measurable depth with an area of 20 square cm. On 07/16/26 at 12:35 p.m., CNA #4 stated they had set a reminder on their phone to reposition Resident #3 every two hours. CNA #4 stated Resident #3 remained in the same position because they did not have enough time to reposition every two hours while Resident #3 was in bed, as they were the only staff member assigned to that hall. On 07/16/26 at 3:16 p.m., the DON stated it was not acceptable to keep a resident in the same position for more than two hours if they were unable to reposition.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure urinary catheter bags were not placed on trash cans or allowed to touch the floor for 1 (#7) of 1 sampled resident reviewed for urinary catheters. The DON identified two residents with urinary catheters resided in the facility. Findings: On 07/15/26 at 8:52 a.m., Resident #7 was observed in their room sitting in their recliner. Resident #7's urinary catheter bag was observed hanging on a small trash can beside the recliner and touching the floor. On 07/16/26 at 9:53 a.m., Resident #7's urinary catheter bag was observed hanging on a small trash can beside their recliner and touching the floor. A policy titled Catheter Care Guideline, dated 03/01/25, read in part, Ensure care aligns with safe and effective management of urinary catheters and reduce the risk of infection and promote resident comfort and dignity. A physician's order for Resident #7, dated 07/02/26, showed catheter care every shift and as needed. A significant change assessment for Resident #7, dated 07/04/26, showed the resident's cognition was severely impaired with a BIMS score of 2. The assessments showed the resident had a diagnosis of renal disease. A care plan for Resident #7, dated 07/09/26, read in part, The resident has an indwelling urinary catheter; position the catheter bag and tubing below the level of the bladder. On 07/16/26 at 9:56 a.m., CNA #1 stated they always hung the catheter bag on the trash can when a resident was in their recliner. On 07/16/26 at 9:58 a.m., LPN #1 stated the catheter bag was always hung on the trash can when a resident sat in their recliner, but it should not touch the floor. On 07/16/26 at 10:08 a.m., the DON stated staff was encouraged not to hang the urinary catheter bag on the trash can, and it should not touch the floor. On 07/16/26 at 10:10 a.m., the regional nurse consultant stated a urinary catheter bag that was hung on the trash can and was allowed to touch the floor caused a concern for infection control.		