STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375206	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Nursing & Rehab	1103 West Cherokee Lindsay, OK 73052

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 34333 Based on record review and interview, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form to three (#13, #53, and #56) of three residents reviewed for beneficiary notification. The Administrator reported 63 residents resided in the facility. Findings: 1. Resident #56 was admitted to Part A skilled services on 05/07/24 and discharged from skilled services on 07/26/24. 2. Resident #53 was admitted to Part A skilled services on 09/19/24 and discharged from skilled services on 09/11/24. 3. Resident #13 was admitted to Part A skilled services on 11/18/24 and discharged from skilled services on 12/11/24. On 12/17/24 at 12:58 p.m., the MDS coordinator and DON provided documentation to be reviewed for beneficiary notification. The DON reported no SNF ABN form was provided to residents #13, #53, #56, and/or their representative. The DON reported the facility had not been completing a SNF ABN form for residents or providing this information in any form. On 12/17/24 at 1:03 p.m., RN #1 reported the SNF ABN form was previously included in the resident admission packet but was no longer a part of the packet. The RN stated she didn't know when it was removed from the packet, but it would be added immediately to ensure it was not missed.

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