

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/17/2025
NAME OF PROVIDER OR SUPPLIER  Ranchwood Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  824 South Yukon Parkway Yukon, OK 73099	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462</b></p> <p>Based on record review and interview, the facility failed to conduct a thorough investigation after receiving an allegation of missing doses of medication for one (#8) of three sampled residents reviewed for medications being administered as ordered.</p> <p>The administrator reported there were 112 residents residing in the facility.</p> <p>Findings:</p> <p>An Abuse, Neglect and exploitation and misappropriation of resident property policy, reviewed 02/12/20, read in parts, All facility staff members have a duty to ensure that all alleged violations .including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, who serves as the Abuse Coordinator .Upon receiving an allegation .the Abuse Coordinator will .initiate an investigation into the allegation.</p> <p>Resident #8 had diagnoses which included type 2 diabetes mellitus and end stage renal disease.</p> <p>A physician's order, dated 12/23/24, documented Resident #8 was to receive Ozempic 2mg via subcutaneous injection every Wednesday.</p> <p>The MAR for December 2024 documented Ozempic 2mg via subcutaneous injection was administered on 12/04/24, 12/11/24, 12/18/24, and 12/25/24.</p> <p>The MAR for January 2024 documented Ozempic 2mg via subcutaneous injection was administered on 01/01/25 and 01/08/25.</p> <p>On 01/14/25 at 8:30 a.m., Resident #8 was asked if they received their medications as ordered. They reported having a problem getting the correct dosage of Ozempic for a period of three weeks in December when the physician changed the order. Resident #8 stated, One week I did not get it at all.</p> <p>On 01/16/25 at 9:27 a.m., Resident #8 stated, Yesterday when it was time for me to get my medicine, [RN #2] came and told me [they] had laid my Ozempic pen out on the counter to warm and came back and could not find it. [They] told me maybe someone took it, and the facility will have to order me some more and pay for it. Now they have it locked up. I know there was at least two doses left in that pen because they give the pen to me, and I take my own shot. I told the nurse.</p> <p>(continued on next page)</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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/16/25 at 1:00 p.m., RN #2 reported there were one or two doses of Ozempic remaining in Resident #8's medication pen after administering their dose on 01/08/25, but when they went to get the pen out of the refrigerator yesterday it was not there. RN #2 stated they reported this to the DON immediately and a STAT order was placed for a replacement pen.</p> <p>On 01/16/25 at 3:22 p.m., the DON was asked if RN #2 had reported Resident #8 was missing an Ozempic pen on 01/15/25 with two medication doses remaining in it. They stated, We tried to find it. Maybe it got misplaced or discarded. The DON was asked if an investigation was initiated. They stated, No. The DON was asked if this was reported to the administrator. They stated, No.</p> <p>On 01/16/25 at 4:59 p.m., the pharmacist confirmed that, according to when Resident #8's prescriptions for Ozempic had been filled, on 01/05/25 there would have been two doses of Ozempic remaining in the medication pen that was delivered to the facility on [DATE].</p> <p>On 01/16/25 at 5:11 p.m., the administrator was asked if an investigation had been initiated related to Resident #8's report of having two remaining doses of medication in their Ozempic pen that went missing on yesterday. The administrator stated they were not aware of the incident and an investigation should have been initiated.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45462</p> <p>Based on record review and interview, the facility failed to complete a comprehensive MDS assessment within the required time frame for one (#6) of eleven sampled residents reviewed for MDS assessment completion.</p> <p>The DON identified 112 residents resided in the facility.</p> <p>Findings:</p> <p>The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1, dated October 2024, documented an admission assessment must be completed no later than the 14th day of the resident's admission.</p> <p>Resident #6 was admitted on [DATE] with diagnoses which included type 2 diabetes mellitus and stage 4 pressure ulcer of sacral region.</p> <p>There was no documentation in the EHR that a comprehensive MDS assessment was completed for Resident #6.</p> <p>On 01/15/25 at 3:45 p.m., the DON was asked to review Resident #6's clinical record. After consulting with the MDS coordinator, the DON acknowledged no comprehensive MDS assessment had been completed for Resident #6 since their admission on 12/02/24.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45462</p> <p>Based on record review and interview, the facility failed to ensure a resident did not receive the wrong medications for one (#3) of three sampled residents reviewed for medication being administered as ordered.</p> <p>The administrator identified 112 residents resided in the facility.</p> <p>Findings</p> <p>A Medication Administration- General Guidelines policy, dated 01/2024, read in parts, Residents are identified before medication is administered using at least two resident identifiers .the resident's room number or physical location is not used as an identifier</p> <p>Resident #3 had diagnoses which included pneumonia and deep vein thrombosis.</p> <p>An incident report, dated 12/25/24 at 8:02 a.m., documented CMA #2 had given Resident #3 medications that belonged to another resident.</p> <p>A nurses note, signed 12/25/24 2:10 p.m., documented CMA #2 reported giving Resident #3 the following medications that belonged to another resident: aspirin 81mg (NSAID- reduce risk of heart attack), buspirone 10mg (anxiolytic- treats anxiety), linezolid 600mg (antibacterial- treats skin infection &amp; pneumonia), and potassium chloride 10mEq (electrolyte supplement- treats low blood levels of potassium).</p> <p>On 01/15/25 at 3:45 p.m., the DON acknowledged the incident had occurred and asked if it would be considered past non-compliance. The DON was asked if there was documentation after becoming aware of the incident, it had been reviewed by the QAPI committee, documentation CMA #2 and other staff authorized to administer medications had been in-serviced, and interventions had been implemented to prevent a reoccurrence of this type of incident. No documentation was provided.</p> <p>On 01/16/25 at 12:46 p.m., CMA #2 was asked how they identified residents when administering medications. They stated the residents have pictures that show up in the EHR, their names are posted outside the door, and after a while you get to know them.</p>		