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Form Approved OMB
No. 0938-0391

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 03/05/2026
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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record review, and interview, the facility failed to ensure the hall 8 computer on top of the treatment cart was locked and secured to prevent the exposure of resident medical records for 1 of 1 treatment cart observed. The administrator identified 105 residents resided in the facility. Findings:On 03/04/26 at 12:26 p.m., LPN #1 was observed on hall 8 to leave the treatment cart and go inside of a room. The treatment cart had a laptop computer on top that was unlocked with the screen exposed, showing medical records from the electronic medical record. The treatment cart and computer were positioned in front of the room slightly sideways near the wall with the front of the computer screen facing the hallway. On 03/04/26 at 12:27 p.m., an unknown resident was observed to walk up to the cart, face the computer, and talk to LPN #1 from the door, while LPN #1 was inside the room. A policy titled Medication Administration, dated 01/2024, read in part, Resident's health information needs to remain private. The pages of the MAR notebook containing resident health information must remain closed or covered when not in direct use. On 03/04/26 at 12:29 p.m., LPN #1 stated they did not think it was a big deal since they came right back. LPN #1 stated they were not sure how to lock the computer screen.On 03/04/26 at 2:32 p.m., the regional consultant and the DON stated the policy and procedure for securing computers was to minimize the screen or close it when not actively used by staff.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure timely incontinent care was provided for 1 (#3) of 2 sampleds resident observed for incontinent care.The administrator identified 105 residents resided in the facility. Findings:On 03/04/26 at 1:50 p.m., there was a strong odor of urine and an overly urine saturated brief in the trash can observed in Resident #3's room. On 03/04/26 at 1:58 p.m., Resident #3's family member was observed to remove the blanket, sheet, and cloth pad and place on the floor. The bed was observed to have a wet ring in the center of the mattress. A policy titled Perineal Care, dated 04/10/23, read in part, Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection. Dispose of gloves and used supplies and perform hand hygiene. Apply new gloves and place new brief and change linens as needed.A resident admission assessment for Resident #3, dated 02/11/26, showed the resident was cognitively intact with a brief score for mental illness of 14. The assessment showed the resident required partial/moderate assistance with toileting and was dependent for bed mobility. The assessment showed Resident #3 was occasionally incontinent of bladder.On 03/04/26 at 1:52 p.m., Resident #3 stated they were not soiled.On 03/04/26 at 2:00 p.m., Resident #3 stated the staff had gotten them up out of bed just before lunch. On 03/04/26 at 2:03 p.m., CNA #1 stated Resident #3 was in bed when they got to their room around 1:00 p.m. or earlier to get the resident out of bed. They stated when they got the resident out of bed for therapy, they were wet. CNA #1 stated they changed their clothes. CNA #1 verified the sheet on the bed was wet and the linen and pad on the floor was wet. On 03/04/26 at 2:05 p.m., CNA #1 stated they did not make the bed after getting Resident #3 up. On 03/04/26 at 2:09 p.m., the DON stated the process for getting incontinent residents up was for staff to check if the resident was clean and dry and to clean if not and to check every two hours at minimum. The DON stated linens were to be changed as needed when soiled, upon request, and at minimum twice weekly. The DON stated the expectation for when a bed was wet was for the staff to change the bed and resident, for both to be clean and dry.On 03/04/26 at 2:12 p.m., the DON verified they observed the wet linen and the wet ring on Resident #3's bed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure medication was available for administration as ordered for 1 (#1) of 3 sampled residents reviewed for medication administration. The administrator identified 105 residents resided in the facility. Findings:A policy titled Medication Administration, dated 01/2024, read in part, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices.A physician order for Resident #1, dated 02/17/25, showed the resident was to receive divalproex (anticonvulsant) 125 mg one tablet by mouth every 12 hours for unspecified dementia.A physician order for Resident #1, dated 06/04/25, showed the resident was to receive levothyroxine (thyroid hormone) 150 micrograms one tablet by mouth at early morning time for hypothyroidism. A 02/2026 MAR for Resident #1 showed:a. levothyroxine was held on 02/07/26 at 6:00 a.m., due to being unavailable,b. levothyroxine was held on 02/08/26 at 6:00 a.m., due to being unavailable,c. levothyroxine was held on 02/12/26 at 6:00 a.m., due to no documentation,d. levothyroxine was held on 02/14/26 at 6:00 a.m., due to being unavailable,e. levothyroxine was held on 02/15/26 at 6:00 a.m., due to being unavailable,f. levothyroxine was held on 02/16/26 at 6:00 a.m., due to being unavailable,g. divalproex was held on 02/15/26 at 9:00 a.m., due to being unavailable, andh. divalproex was held on 02/16/26 at 9:00 a.m., due to being unavailable.On 03/05/26 at 10:11 a.m., CMA #2 stated the process to ensure medications were available was to order medications daily. They stated typically they should order when down to five days or less, and if the medication was not in the building to call the pharmacy and let the nurse know. CMA #2 stated when a medication was not available, they left the medication up on the MAR and would notify the nurse, pharmacy, and then the DON. On 03/05/26 at 10:22 a.m., the DON and regional consultant stated medications should be ordered when down to a seven-day supply and if was not available they were to notify the physician and DON and order STAT from pharmacy. On 03/05/26 at 2:31 p.m., CMA #1 stated H on the MAR indicated hold. Upon review of the MAR for 02/2026 for Resident #1, CMA #1 stated the following:a. levothyroxine was held on 02/07/26 at 6:00 a.m., due to being unavailable,b. levothyroxine was held on 02/08/26 at 6:00 a.m., due to being unavailable,c. levothyroxine was held on 02/12/26 at 6:00 a.m., due to no documentation,d. levothyroxine was held on 02/14/26 at 6:00 a.m., due to being unavailable,e. levothyroxine was held on 02/15/26 at 6:00 a.m., due to being unavailable,f. levothyroxine was held on 02/16/26 at 6:00 a.m., due to being unavailable,g. divalproex was held on 02/15/26 at 9:00 a.m., due to being unavailable, andh. divalproex was held on 02/16/26 at 9:00 a.m., due to being unavailable.CMA #1 stated the medications were not in the building since it was unavailable and needed to be ordered STAT.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the treatment cart for hall 8 was secure when staff were not in attendance for 1 of 1 treatment cart observed. The administrator identified 105 residents resided in the facility. Findings:On 03/04/26 at 12:26 p.m., LPN #1 was observed on hall 8 to leave the treatment cart and go inside of a room. The treatment cart was not locked. The treatment cart was positioned in front of the room slightly sideways near the wall with the front of the cart facing the hallway. On 03/04/26 at 12:27 p.m., an unknown resident was observed to walk up to the front of the treatment cart and talk to LPN #1 from the door, while LPN #1 was inside the room. A policy titled Medication Administration, dated 01/2024, read in part, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse.The cart must be clearly visible to the personnel administering medications when unlocked.On 03/04/26 at 12:29 p.m., LPN #1 stated they did not think it was a big deal since they came right back. On 03/04/26 at 2:32 p.m., the regional consultant and the DON stated the policy and procedure for treatment/medication cart storage, was anytime not in attendance of the cart they were to be locked.

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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 hand hygiene practices were maintained during the provision of perineal care for 1 (#4) of 2 sampled residents observed for incontinent care. The administrator identified 105 residents resided in the facility. Findings:On 03/04/26 at 11:18 a.m., CNA # 2 was observed to begin incontinent care on Resident #4. CNA #2 obtained wipes, performed perineal care to the front, then turned the resident onto their side. Resident #4 had a bowel movement. On 03/04/26 at 11:21 a.m., CNA #2 was observed to wipe the stool off of Resident #4 with a wipe. CNA #2 was observed to wipe stool that was on their left gloved hand onto the pad under the resident. CNA #2 placed a clean brief under Resident #4 and proceeded to touch the wipes package and place them on the resident's table, turned the resident back over, touched the resident, the wipes package, and cleaning solution with the same gloves. CNA #2 did not change their gloves. On 03/04/26 at 11:22 a.m., CNA #2 was observed to fasten Resident #4's clean brief, remove the soiled pad, and place it at the foot of the bed. CNA #2 put clean pants on Resident #4. CNA #2 did not change gloves. On 03/04/26 at 11:24 a.m., CNA #2 was observed to touch Resident #4's covers and draw sheet with the same gloved hands.On 03/04/26 at 11:25 a.m., CNA #2 was observed to remove their gloves, took the trash, and left the room. CNA #2 did not sanitize their hands after removing the gloves or before grabbing the trash. There was no observation the CNA #2 performed hand hygiene. A policy titled Perineal Care, dated 04/22/24, read in part, Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection.Remove feces present.Dispose of gloves and used supplies and perform hand hygiene. Apply new gloves and place new brief and change linens as needed. A 5-day resident assessment for Resident #4, dated 12/26/25, showed the resident was dependent for toileting and bed mobility. The assessment showed Resident #4 was frequently incontinent of bowel and bladder and had active diagnosis of urinary tract infection and septicemia (infection in the blood).On 03/04/26 at 12:30 p.m., CNA #2 stated gloves were to be changed after cleaning stool and after completed with incontinent care. CNA #2 stated they did not think they changed their gloves because they were nervous.