

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  03/26/2026
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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to provide sufficient staff to ensure the highest practicable well-being of each resident. The director of nurses reported 98 residents resided in the facility. The Quality of Care Monthly Report dated December 2025 showed 3 days with insufficient direct care staff for the reported resident census. The Quality of Care Monthly Report dated January 2026 showed 5 days with insufficient direct care staff for the reported resident census. The Quality of Care Monthly Report dated February 2026 showed 1 day with insufficient direct care staff for the reported resident census. A Bath List provided by the facility showed Res. #1 in room [ROOM NUMBER]A was to have baths on Monday and Thursday every week. Facility provided Bath Sheet documents showed Resident #1 had baths on 03/05/26, 03/19/26, and 03/24/26. A Bath List provided by the facility showed Res. #8 in room [ROOM NUMBER]B was to have baths every Tuesday, Thursday and Saturday. Facility provided Bath Sheet documents showed Resident #8 had baths on 03/05/26, 03/14/26, 03/19/26, and 03/24/26. A Bath List provided by the facility showed Res. #9 in room [ROOM NUMBER]B was to have baths on Wednesday and Saturday every week. Facility provided Bath Sheet documents showed Resident #9 had a complete bed bath on 01/16/26 and 01/21/26, and had a shower on 03/05/26. On 03/25/26 at 8:45 a.m., CNA #1 stated the residents do not get incontinent care, baths or showers as often as they needed due to staffing. CNA #1 stated they will leave them for the next shift but often they are short staff so they never get done. On 03/25//26 at 10:20 a.m., CNA #2 stated they were short staffed at times and do not have enough people to help with residents that require more than one person transfer. CNA #2 stated residents that require more assistance often do not get baths or showers. On 03/25/26 at 3:10 p.m., the DON stated they did not have additional bath sheets. The DON stated they do not have a good process for bath or shower sheet completion and feels like more have been done than turned in. The DON stated they were not sure how many baths were actually getting done.</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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