STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375229	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ranchwood Nursing Center	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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician and family were notified when a resident had a change of condition for 1 (#6) of 3 sampled residents reviewed for a change of condition which resulted in death. Resident #1 had low blood pressure of 73/47, 81/59 and a pulse of 41 without notification to the physician of the change. The MDS coordinator identified 105 residents resided in the facility.On 04/10/26, an IJ situation was determined to exist related to the facility's failure to notify the physician and family of a change in condition for Resident #6 who was reported to have a low blood pressure and pulse which resulted in death.On 04/10/26 at 11:55 a.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On 04/10/26 at 11:57 a.m., the administrator and DON were verbally notified of the IJ in existence and provided the IJ template via email at 12:01 p.m.On 04/13/26 at 1:14 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal read in part, Ranchwood Nursing and Rehab Plan of Removal: 04/10/2026 F580- Notification of Physician This POR is in response to the facility's alleged failure to notify the physician and family when a resident experiences a change in condition with abnormal vital signs which places all residents at risk for serious harm, serious injury, serious impairment, or death.The DON was promptly educated on the identification and monitoring of abnormal vital signs and notification of physicians and family members when abnormal vital signs are obtained, or when there is a change in condition as defined by F580 as:An accident involving the resident which results in injury and has the potential for requiring physician intervention;A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life- threatening conditions or clinical complications);A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); orA decision to transfer or discharge the resident from the facility DON was re-educated by Regional Nurse Consultant at 12:15 pm verbalized understanding and has demonstrated competency in recognition of abnormal vital signs.The DON/designee will educate licensed staff on abnormal vital signs and notification of physician for change of condition to be completed on 4/10/2026 at 11:59 pm.No licensed nursing staff will be allowed to work until education on notification of physician is given. Staff not receiving education on 4/10/2026 will receive education prior to the start of their next shift.Medical Director was contacted at 4/10/2026 at 12:55 p.m.An audit of currently recorded vital signs was completed to verify that there are no current residents with vital signs outside of normal limits or parameters provided by the physician.DON/designee will monitor abnormal vital signs as defined by the parameters provided by physicians or those congruent with standards of practice 5 times weekly during morning meeting to identify change of condition and notification of physician. Issues identified will be corrected immediately.Submitted to QAPI for review on 4/10/2026 at 1 pm.The IJ was lifted, effective 04/13/26 at 2:45 p.m., when all components of the plan of removal had been verified as completed. A review of the resident audits was conducted. In-service training regarding notification of changes was reviewed, and staff were interviewed to ensure the in-service (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	training had been completed. The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy . Findings:A physician's note, dated 02/03/26, showed Resident #6 was assessed. The note showed their blood pressure was 110/66 with a pulse of 77. The note showed the physician assessed Resident #6 for dehydration and ordered one liter of intravenous normal saline (a sterile solution of sodium chloride in water often used for dehydration).A comprehensive admission assessment for Resident #6, dated 02/17/26, showed they were admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), acute kidney injury, multi-drug resistant organisms, urinary tract infection, sepsis, and diabetes mellitus.A vital sign log for Resident #6, dated 02/18/26, showed the resident's blood pressure was 73/47 and their oxygen saturation was 84% on room air. There was no documentation in Resident #6's health chart that showed the physician was notified of their change of blood pressure and oxygen saturation. There was no documentation Resident #6 had been seen by the nurse practitioner on 02/18/26.A nurse's note for Resident #6, dated 02/21/26, showed they were unable to be aroused with a blood pressure of 81/59 and a pulse of 41. Resident #6 had three plus pitting edema to both arms and cold, purple fingers. The note showed the physician was notified and ordered a 500cc bolus of normal saline for hydration. The note showed the physician stated if no improvement to send Resident #6 to the emergency room.A vital sign log for Resident #6, dated 02/22/26, showed the resident's pulse was 48. There was no documentation Resident #6 had been seen by the nurse practitioner on 02/22/26.There was no documentation in Resident #6's health chart that showed the physician was notified of their abnormal pulse.A nurse's note for Resident #6, dated 02/23/26, showed the resident was found unresponsive with a pulse of 28 and was sent to the emergency room.An emergency room physician's note for Resident #6, dated 02/23/26, showed the resident had a blood pressure of 71/44, a temperature of 88.2 degrees Fahrenheit, and was ill-appearing. The note showed Resident #6 had a blood glucose level of less than 20. The note showed Resident #6 was verbally and physically unresponsive, critically ill with low blood pressure, and had a high likelihood of death. An e-mail sent by RN #1 as a late entry nurse's note, dated 04/03/26, showed Resident #6 returned to the facility while actively dying. The e-mail showed Resident #6 passed away on 02/24/26 at 5:30 a.m.A Certificate of Death for Resident #6, dated 03/26/26, showed the resident's cause of death was protein calorie malnutrition, cognitive impairment disorder, and acute kidney failure. The Certificate of Death showed a significant condition contributing to Resident #6's death was diabetes mellitus. A policy titled Change of Condition, dated 02/13/23, read in part, Patient families, guardians, or other appropriate people are to be contacted when there is a significant change in a patient's condition or health status.On 04/09/26 at 11:02 a.m., Resident #6's family member stated there had been no communication from the facility regarding Resident #6's physical condition. Resident #6's family member stated on 02/23/26, the emergency room notified them of Resident #6's condition. The family member stated Resident #6 was actively dying, so they approved transfer back to the facility to pass away.On 04/09/26 at 11:51 a.m., LPN #1 stated they would notify the nurse practitioner or physician of a resident's pulse that was less than 60. LPN #1 stated on 02/22/26, they notified the nurse practitioner of Resident #6's low pulse of 48 and documented the pulse rate in Resident #6's health chart. LPN #1 was asked to show the documentation of notification, and they stated they could not find it. LPN #1 stated they did not notify the family of Resident #6's low pulse.On 04/09/26 at 12:51 p.m., the ADON stated they would report a blood pressure less than 110/60 and an oxygen saturation less than 90% to the physician or nurse practitioner. The ADON stated they notified the nurse practitioner for Resident #6's blood pressure of 73/47 and oxygen saturation of 84% on 02/18/26. The ADON stated they could not recall if they spoke with them or left a message and did not recall any orders given by the nurse practitioner. The ADON stated they usually documented notifications in the residents' health chart, but could not remember if they documented the notification on 02/18/26.On 04/10/26 at 10:28 a.m., the nurse practitioner stated they did not recall notification of abnormally low vital signs regarding Resident #6 on 02/18/26 or 02/22/26. The nurse practitioner stated the only notification of change they had received were on the days Resident #6 was seen in person by them.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a care plan:a. for a resident who had a diagnosis of diabetes mellitus type 2 and acute kidney injury for 1 (#6) of 3 sampled residents reviewed for care plans. Resident #1 had no care plan for glucose levels and showed the resident's cause of death was protein calorie malnutrition, cognitive impairment disorder, and acute kidney failure. The Certificate of Death showed a significant condition contributing to Resident #6's death was diabetes mellitus.b.to include interventions for weight loss for 1 (#1) of 3 sampled residents reviewed for weight loss.The MDS coordinator identified 105 residents resided in the facility.Findings: 1. A facility policy titled Care Plan Process, dated 03/27/23, read in part, The plan of care identifies the date, problem, goals, measurable and realistic, time frames for achievement, interventions, discipline specific services, resolution/goal analysis, and [sic] discharge option.A care plan for Resident #6, dated 01/22/26, did not identify acute kidney injury or diabetes mellitus type 2 as diagnoses. A comprehensive admission assessment for Resident #6, dated 02/17/26, showed the resident was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2 and acute kidney injury.A nurse's note for Resident #6, dated 02/23/26, showed the resident was found unresponsive with a pulse of 28 and was sent to the emergency room.An emergency room physician's note for Resident #6, dated 02/23/26, showed the resident had a blood pressure of 71/44, a temperature of 88.2 degrees Fahrenheit, and was ill-appearing. The note showed Resident #6 had a blood glucose level of less than 20. The physician's note showed Resident #6 was verbally and physically unresponsive, critically ill with low blood pressure, and had a high likelihood of death. A Certificate of Death, for Resident #6 dated 03/26/26, showed the resident's cause of death was protein calorie malnutrition, cognitive impairment disorder, and acute kidney failure. The Certificate of Death showed a significant condition contributing to Resident #6's death was diabetes mellitus.On 04/10/26 at 8:36 a.m., the DON stated Resident #6 should have had a care plan for monitoring their kidney injury and failure and diabetes mellitus type 2.2. A Nutrition Therapy Assessment for Resident #1, dated 03/25/26, showed recommended interventions of encourage fluid intake with meals and snacks, frozen nutrition treat, and weekly weights.A Physician Order for Resident #1, dated 03/25/26, showed weekly weights on day shift times four weeks or until stable.An undated care plan for Resident #1 did not show the recommended interventions.An undated weight report for Resident #1 showed the resident had a weight loss of 7.7 pounds or 8.5% in 6 months from 10/2025 to 04/2026.A quarterly assessment for Resident #1, dated 01/29/26, showed their BIMS was a 3 indicating severe cognitive impairment and a diagnosis of severe protein calorie malnutrition. On 04/08/26 at 11:04 a.m., the MDS coordinator stated they updated the care plans when a 10% change in weight loss or gain occurred. The MDS coordinator stated the interventions were not updated on Resident #1's care plan.On 04/08/26 at 11:25 p.m., the MDS coordinator stated the interventions shown on the nutrition therapy assessment were appropriate and should have been on the care plan. On 04/08/26 at 11:35 p.m., the DON stated their expectations for updating the care plans would ideally be within 24 hours. They stated the interventions should have been updated on the plan of care.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promptly assess, identify, and intervene when a resident experienced an acute emergent change in condition for 1 (#6) of 3 sampled residents reviewed for changes in conditions when facility staff failed to notify the medical provider of critical emergent vital signs/symptoms and identify hypoglycemia on a resident with known history of diabetes and known recent history and hospitalizations for hypoglycemia resulting in transfer to the acute care hospital and subsequent death.Specifically, the facility failed to:a. Identify, monitor, intervene, and provide continuing assessments for Resident #6 who was admitted with a known history of diabetes and hypoglycemia experiencing signs and symptoms of hypoglycemia.b. Notify the medical provider of, or intervene, for Resident #6's critically abnormal vital signs of a blood pressure of 73/47 and an oxygenation of 84% on [DATE], andc. Notify the medical provider of, or intervene, for Resident #6's critically abnormal vital signs/symptoms of a blood pressure of 81/59, pulse of 41, and unresponsive status on [DATE].These failures led to Resident #6 transferring to the acute care hospital on [DATE] where they were identified to have a blood pressure of 71/44, temperature of 88.2 degrees Fahrenheit, blood glucose of 20, and described as ill-appearing with a high likelihood of death. The resident was identified as actively dying and returned to the facility where they ultimately expired on [DATE].The MDS coordinator identified four residents required monitoring for diabetes type 2 mellitus resided in the facility.On [DATE], OSDH was contacted and confirmed an immediate jeopardy (IJ) situation was determined to exist related to the facility's failure to adequately monitor finger stick blood sugars and intervene for Resident #6 who had a diagnosis of diabetes mellitus type 2 and was found unresponsive with hypoglycemia.On [DATE] at 11:55 a.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On [DATE] at 1:14 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Ranchwood Nursing and Rehab Plan of Removal: [DATE] F684- Monitor Blood glucose The facility's alleged failure to monitor and intervene for a resident who had a diagnosis of diabetes mellitus type 2 places all diabetic residents at risk for serious harm, serious injury, serious impairment, or death.An audit was completed of all residents with diabetes and oral agents to ensure monitoring of hypoglycemia signs and symptoms. Orders in place. Completed on [DATE]DON was promptly educated by Regional Nurse Consultant at 12:15 pm on [DATE] on monitoring for signs and symptoms of diabetes mellitus type 2, appropriate notifications and protocols to intervene. DON verbalized understanding and demonstrated competency.The DON/designee will educate licensed staff on recognizing signs and symptoms of hypoglycemia and protocol to intervene.All residents identified as receiving oral medication for the treatment of hypoglycemia had their blood sugar checked by 11:59 pm on [DATE].Medical Director was contacted at [DATE] at 12:55pm.No licensed nursing staff will be allowed to work until education on hypoglycemic protocol is given. Staff not receiving education on [DATE] will receive education prior to the start of their next shift.DON/designee will monitor clinical records 5 times weekly for changes related to potential hypoglycemia and follow up completedSubmitted to QAPI for review on [DATE] at 1:00 pm.b. intervene for Resident #6 who had low blood pressure, pulse, and oxygen readings with a diagnosis of acute kidney injury and was found unresponsive.On [DATE] at 11:57 a.m., the administrator and DON were verbally notified of the IJ in existence and provided the IJ template via email at 12:01 p.m.On [DATE] at 1:14 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Ranchwood Nursing and Rehab Plan of Removal: [DATE] F684- Change of Condition The facility's alleged failure to monitor and intervene when a resident experiences a change in condition with abnormal vital signs which places all residents at risk for serious harm, serious injury, serious impairment, or death.DON was promptly educated on the identification and monitoring of abnormal vital signs and notification of physicians and family (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	members when abnormal vital signs are obtained, or when there is a change in condition as defined by F580 as:An accident involving the resident which results in injury and has the potential for requiring physician intervention:A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life- threatening conditions or clinical complications);A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); orA decision to transfer or discharge the resident from the facility DON was re-educated by Regional Nurse Consultant at 12:15 pm verbalized understanding and has demonstrated competency in recognition of abnormal vital signs.The DON/designee will educate licensed staff on abnormal vital signs and notification of physician for change of condition, to by [sic] completed by [DATE] 11:59 pm.No licensed nursing staff will be allowed to work until education on hypoglycemic protocol is given. Staff not receiving education on [DATE] will receive education prior to the start of their next shift.All vital signs were reviewed for abnormal results by 11:59 pm on [DATE].Medical Director was contacted at [DATE] at 12:55pm.DON/designee will monitor abnormal vital signs 5 times weekly during morning meeting to identify changes in condition and notification of physician and family. Issues identified will be corrected immediately.Submitted to QAPI for review on [DATE] at 1:00 pm.The IJs were lifted, effective [DATE] at 2:45 p.m., when all components of the plans of removal had been verified as completed. A review of the resident audits was conducted. In-service training regarding notification of changes was reviewed, and staff were interviewed to ensure the in-service training had been completed. The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings:An undated vital sign log showed no finger stick blood sugar monitoring for Resident #6 from [DATE] through [DATE].Medication administration records for Resident #6, dated January and February 2026, showed the resident had taken Metformin (a blood sugar lowering medication) 500mg twice daily and glimepiride (a blood sugar lowering medication) 1mg once daily. The medication administration records showed the resident was prescribed Glutose (a low blood sugar antidote) 15gm gel by mouth and glucagon (a low blood sugar antidote) 1mg emergency kit injected, both as needed as blood sugar check required. There were no parameters on the order to indicate what level of blood sugar would require administration of Glutose or glucagon.A hospital physician's note for Resident #6, dated [DATE], showed the resident had been hypoglycemic (low blood sugar) with a finger stick blood sugar of 36 upon arrival to the emergency room.A care plan for Resident #6, dated [DATE], showed no interventions for acute kidney injury or diabetes mellitus type 2.A physician's note for Resident #6, dated [DATE], showed the resident was assessed. The note showed their blood pressure was 110/66 with a pulse of 77. The note showed the physician assessed the resident for dehydration and ordered one liter of intravenous normal saline (a sterile solution of sodium chloride in water commonly used for dehydration).A hospital discharge summary for Resident #6, dated [DATE], showed the resident had been hospitalized from [DATE] to [DATE] for hypoglycemia.A comprehensive admission assessment for Resident #6, dated [DATE], showed the resident was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2, hypertension, and acute kidney injury.A vital sign log for Resident #6, dated [DATE], showed the resident's blood pressure was 73/47 and their oxygen saturation was 84% on room air. There was no documentation in Resident #6's health chart that showed any intervention for their change of blood pressure and oxygen saturation.A nurse's note for Resident #6, dated [DATE], showed the resident was unable to be aroused with a blood pressure of 81/59 and a pulse of 41. Resident #6 had three plus pitting edema (a moderate-to-severe fluid buildup in tissues) to both arms and cold, purple fingers. The note showed the physician was notified and ordered a 500cc bolus of normal saline for hydration. The note showed the physician stated if no improvement to send Resident #6 to the emergency room.A vital sign log for Resident #6, dated [DATE], showed the resident's pulse was 48.There was no documentation in Resident #6's health chart that showed the physician was notified of their abnormal pulse.A nurse's note for Resident #6, dated [DATE], showed the resident (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was found unresponsive with a pulse of 28 and was sent to the emergency room.An emergency room physician's note for Resident #6, dated [DATE], showed the resident had a blood pressure of 71/44, a temperature of 88.2 degrees Fahrenheit, and was ill-appearing. The note showed the resident had a blood glucose level of less than 20. The physician's note showed Resident #6 was verbally and physically unresponsive, critically ill with low blood pressure, and had a high likelihood of death. A Certificate of Death, for Resident #6, dated [DATE], showed the resident's cause of death was protein calorie malnutrition, cognitive impairment disorder, and acute kidney failure. The cause of death showed significant conditions contributing to Resident #6's death was shown as diabetes mellitus.An e-mail sent by RN #1 to the DON, dated [DATE], showed Resident #6 returned to the facility from the emergency room on [DATE], while actively dying. The e-mail showed Resident #6 passed away on [DATE] at 5:30 a.m.A policy titled Change of Condition, dated [DATE], read in part, The primary goal of identifying Acute Changes of Condition (ACOCs) is to enable staff to evaluate and manage a patient at the community and avoid transfer to a hospital or emergency room. Care-giving staff should describe and document the nature, extent, and severity of symptoms, abnormalities, and condition changes clearly and in sufficient detail to help practitioners distinguish their potential causes and consequences. Document in the medical record the date, time, and name of each physician notified, actions taken, and/or patient's response to treatment. Patient families, guardians, or other appropriate people are to be contacted when there is a significant change in a patient's condition or health status. An Acute Change of Condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death.On [DATE] at 11:51 a.m., LPN #1 stated they would notify the nurse practitioner or physician of a resident's pulse that was less than 60. LPN #1 stated on [DATE] they notified the nurse practitioner of Resident #6's low pulse of 48 and documented the notification in Resident #6's health chart. LPN #1 was asked to show the documentation of notification, and they stated they could not find it. LPN #1 stated they did not notify the family of Resident #6's low pulse. LPN #1 stated they did not remember monitoring Resident #6's finger stick blood sugar.On [DATE] at 12:51 p.m., the ADON stated they would report a blood pressure less than 110/60 and an oxygen saturation less than 90% to the physician or nurse practitioner. They stated they notified the nurse practitioner for Resident #6's blood pressure of 73/47 and oxygen saturation of 84% on [DATE]. The ADON stated they could not recall if they spoke with the nurse practitioner or left a message and did not recall any orders given by the nurse practitioner. The ADON stated they usually documented notifications in the residents' health chart, but could not remember if they documented the notification on [DATE]. The ADON stated they were unaware of any orders to monitor Resident #6's finger stick blood sugar.On [DATE] at 1:20 p.m., the DON stated there were no physician orders to monitor Resident #6's finger stick blood sugar, but monitoring should have been done since they were diabetic. The DON stated that laboratory orders for kidney monitoring were on an as needed basis. They stated the nurses should have contacting the nurse practitioner to verify when the laboratory tests were needed.On [DATE] at 10:28 a.m., the nurse practitioner stated they did not recall notification of abnormally low vital signs regarding Resident #6 on [DATE] or [DATE]. They stated the only notification of change they had received were on days Resident #6 was seen in person by the nurse practitioner. The nurse practitioner stated they expected the facility to monitor Resident #6's finger stick blood sugar given hospitalizations for hypoglycemia and diagnosis of diabetes mellitus type 2. The nurse practitioner stated the nurses were expected to notify them of blood pressure changes for laboratory tests to be performed.