

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2025
NAME OF PROVIDER OR SUPPLIER  Skiatook Nursing Home, llc		STREET ADDRESS, CITY, STATE, ZIP CODE  318 South Cherry Skiatook, OK 74070	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from abuse for 2 (#1 and #2) of 3 sampled residents reviewed or abuse. The DON identified 32 residents resided in the facility. Findings: An undated facility policy titled Policy and Procedure Regarding Prohibition of Resident Abuse Including Corporal Punishment, Neglect and exploitation, read in part, Definitions: Abuse is the willing infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. An incident report, dated 07/28/25, showed CNA #2 reported to the administrator CNA #1 got in Resident #1's personal space and forced them to sit on the toilet. The report showed afterward Resident #1 pushed CNA #1, who then pushed the resident back. The report showed CNA #2 reported to the administrator CNA #1 rolled Resident #2 into the wall while changing the resident's bedding. The report showed Resident #2 hit their knees on the wall, causing some discoloration to their knees. 1.An undated admission form showed Resident #1 had diagnoses which included dementia and Alzheimer's disease. A quarterly assessment, dated 11/13/25, showed Resident #1 was severely cognitively impaired with a BIMS of 2.2. An undated admission form showed Resident #2 had diagnoses which included dementia, anxiety, and OCD.A quarterly assessment, dated 11/06/25, showed Resident #2 was moderately cognitively impaired with a BIMS of 9.On 11/18/25 at 11:02 a.m., the administrator stated CNA #2 called them on 07/28/25 and reported on the evening shift of 07/27/25 CNA #1 was rough with Resident #1 by forcing them down onto the toilet. They stated Resident #1 pushed CNA #1 and CNA #1 pushed the Resident #1 back. The administrator stated CNA #2 also reported that while changing Resident #2's bedding CNA #1 rolled Resident #1 into the wall causing bruising to the resident's knees. The administrator stated when they attempted to interview CNA #1 over the phone regarding the incidents, they became belligerent, and stated they were quitting. The administrator stated they did in-services with the staff regarding abuse.</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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NAME OF PROVIDER OR SUPPLIER  Skiatook Nursing Home, llc		STREET ADDRESS, CITY, STATE, ZIP CODE  318 South Cherry Skiatook, OK 74070	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to recognize and submit a report of abuse within 2 hours for 2 (#1 and #2) of 3 sampled residents reviewed for abuse. The DON identified 32 residents resided in the facility. Findings: An undated policy titled Policy and Procedure Regarding Responsibility to Report Allegations of Resident abuse, suspected Criminal Acts, Injury of Unknown Source, Neglect, Misappropriations of Property, and Exploitation, read in part, It is the policy of this facility to act on all allegations of abuse, neglect, misappropriation of resident property, exploitation, injuries of unknow source and suspected criminal acts which include reporting the allegations within the prescribed time frame to the appropriate authorities. An initial incident report made to the OSDH, dated 07/28/25, showed CNA #2 witnessed incidents of abuse on 07/27/25. The report showed CNA #2 reported to the administrator CNA #1 got in Resident #1's personal space and forced them to sit on the toilet. The report showed afterward Resident #1 pushed CNA #1, who then pushed the resident back. The report showed CNA #2 reported to the administrator CNA #1 rolled Resident #2 into the wall while changing the resident's bedding. The report showed Resident #2 hit their knees on the wall, causing some discoloration to their knees. On 11/18/25 at 12:00 p.m., the DON stated abuse incidents must be reported to OSDH within two hours. On 11/18/25 at 12:20 p.m., the administrator stated they expected the staff to report abuse immediately. The administrator stated abuse must be reported to OSDH within 2 hours.</p>		