STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375293	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skiatook Nursing Home,llc	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)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 41220 Based on record review and interview, the facility failed to ensure assessments were transmitted within seven days of completion for eight (#5, 11, 15, 16, 17, 18, 21 and #92) of 14 sampled residents whose assessments were reviewed. The administrator identified 38 residents who resided in the facility. Findings: 1. Resident #5 had diagnoses which included chronic obstructive pulmonary disease. The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/11/24, had been submitted late. 2. Resident #11 had diagnoses which included cardiorespiratory conditions. The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/27/24, had been submitted late. 3. Resident #15 had diagnoses which included depression. The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/20/24, had been submitted late. 4. Resident #16 had diagnoses which included stroke. The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/16/24, had been submitted late. 5. Resident #17 had diagnoses which included stroke. The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/17/24, had been submitted late. 6. Resident #18 had diagnoses which included diabetes mellitus. (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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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/20/24, had been submitted late. 7. Resident #21 had diagnoses which included cardiorespiratory conditions. The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/28/24, had been submitted late. 8. Resident #24 had diagnoses which included bipolar disease. The MDS 3.0 NH Final Validation Report, dated 09/30/24 documented the quarterly assessment, dated 08/20/24, had been submitted late. On 10/04/24 at 10:36 a.m., the administrator stated they were aware MDS assessments were not transmitted timely.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41220 Based on record review and interview, the facility failed to ensure a resident assessment was accurate for one (#31) of 14 sampled residents whose resident assessments were reviewed. The administrator identified 38 residents who resided in the facility. Findings: Resident #31 had diagnoses which included metabolic encephalopathy, dementia, acute pain, and diabetes mellitus. A physician order, dated 05/17/24, documented an order for Cymbalta (SNRI medication) 60 mg. Give 1 capsule by mouth one time a day for depression. A physician assessment, dated July 2024, documented a diagnosis of anxiety. The MDS, dated [DATE], did not document a diagnosis of depression or anxiety. The care plan, dated 08/22/24, did not document a diagnosis of depression or anxiety. On 10/04/24 at 10:36 a.m., the administrator stated they were aware some resident MDS's and care plans were not updated. They stated they had a process in place and were trying to bring all records up to 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41220 Based on interview and record review, the facility failed to ensure comprehensive care plans were accurate for two (#14 and #31) of three sampled residents who were reviewed for revision of care plans. The administrator identified 38 residents who resided in the facility. Findings: 1. Resident #14 had diagnoses which included vascular dementia, chronic obstructive pulmonary disease, dysphagia, and weight loss. The care plan, dated 08/21/24, did not address any issues with food, difficulty eating, or swallowing. A physician order, dated 09/28/24, documented an order for a speech evaluation. A speech evaluation, dated 09/28/24, determined a regular diet, regular texture, and thin consistency for fluids with compensatory strategies was appropriate. The compensatory strategies included chin tuck, effortful swallows, small bits, and reflux precautions. 2. Res #31 had diagnoses which included metabolic encephalopathy and dementia. A physician order, dated 05/10/24, documented an order for hydroxyzine HCl (antihistamine medication) oral tablet 25 mg. Give 1 tablet by mouth every 4 hours as needed for anxiety. A physician order, dated 05/17/24, documented an order for Cymbalta (SNRI medication) 60 mg. Give 1 capsule by mouth one time a day for depression. A physician assessment, dated July 2024, documented a diagnosis of anxiety. The care plan, dated 08/22/24, did not document a diagnoses of depression or anxiety. It did not document behavior monitoring or assessments for side effects of the prescribed medications. On 10/03/24 at 8:36 a.m., the DON stated medications should not be prescribed unless the resident had a diagnosis for that medication and care plans should be updated with new diagnosis and physician order. On 10/03/24 at 10:51 a.m., the DON provided documentation with the diagnosis of anxiety for Resident #31. They stated the diagnoses list in the resident record, including the care plan, had not been updated. On 10/04/24 at 10:36 a.m., the administrator stated they were aware some care plans were not updated. They stated they had a process in place and were trying to bring all records up to date.