STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375324	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee County Nursing Center	1504 North Cedar Avenue Tahlequah, OK 74464

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation and interview, the facility failed to ensure enteral feeding bags were properly labeled for 1 (#60) of 1 resident reviewed for enteral feeding. The DON identified two residents who had enteral tube feedings. Findings: On 07/02/25 at 9:01 a.m., a tube feeding bag filled with tan liquid and a bag filled with clear liquid were infusing per feeding pump at 52cc/hr. The bag was observed to have the date, time and initials written on it. On 07/02/25 at 9:08 a.m., LPN #2 stated they could not tell what formula was in the feeding bag or what resident it was intended for because the feeding bag was not labeled correctly. LPN #2 stated the bag should be labeled with the resident's name, the date, the time it was hung, what formula was in the bag, what the infusion rate should be and the initials of the person that hung the bag. LPN #2 stated without the information, a resident could get the wrong feeding formula

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 and interview, the facility failed to ensure medications were secure for 1 of 2 medication/treatment carts on the South hall. The administrator identified 99 residents resided in the facility. Findings: On 07/02/25 at 10:50 a.m., LPN #1 was observed to draw up insulin to administer to a resident. LPN #1 locked the medication cart leaving the insulin on top of the cart and walked away. On 07/02/25 at 10:52 a.m., LPN #1 stated it was the policy of the facility to lock any medications not being used in the medication cart to prevent other residents, staff or visitors from obtaining the medication. On 07/02/25 at 12:30 p.m., the DON stated it was the facility policy to lock all medications in the medication cart when they were not being given.