STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375347	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McLoud Nursing Center	701 South 8th Street McLoud, OK 74851

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33097 Based on record review and interview, the facility failed to convey remaining funds to the legal representatives of deceased residents within 30 days for two (#1 and #2) three sampled residents reviewed for finances. The assistant administrator identified 10 residents who had discharged from the facility with funds remaining. Finds: A policy titled Conveyance of Resident Funds documented .The resident's personal funds and a final accounting of funds are returned to the resident, the resident's representative or to the resident's estate (individual or probate jurisdiction per state law), as applicable, within thirty (30) days from the date of the resident's discharge or eviction from the facility, or death . 1) Res #1 was admitted to facility on [DATE] and discharged on [DATE]. A form documented invoice search with a check request date identified as [DATE]. The form documented an invoice amount of $1,010.62 and a check was sent on [DATE]. 2) Res #2 was admitted to the facility on [DATE] and discharged on [DATE]. A form documented invoice search with a check request date identified as [DATE]. The form documented an invoice amount of $1,649.00 and a check was mailed on [DATE]. On [DATE] at 10:05 a.m., a telephone interview was conducted with the corporate BOM. The BOM stated the remaining funds for the residents were late being processed. The BOM stated no excuse, they just fell between the cracks.

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