

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER McCloud Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 South 8th Street McCloud, 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to: a. ensure assistive devices were used to prevent accidents for 1 (#4) of 15 sampled residents reviewed for accidents; and b. ensure the temperatures of the hot water in residents' rooms and bathrooms were safe to prevent potential burns. The DON identified 16 residents required the assistance of a mechanical lift and 55 residents required assistance with showers. Findings: On 07/21/26 at 5:17 p.m., Resident #4 was observed in a geriatric chair with a mechanical lift sling under the resident in the dining room. A care plan for Resident #4, dated 04/04/19, showed the resident required extensive assistance with ADL care. The care plan showed Resident #4 required a mechanical lift to transfer and two staff to assist in the transfers. A policy titled Safe Lifting and Movements of residents, revised 06/2017, read in part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. A policy titled Hazardous Areas, Devices and Equipment, dated 06/2024, read in part, 3. Resident vulnerability is based on risk factors including the individual's resident's functional status, medical condition, cognitive abilities, mood, and health treatments. 5. Improper or inappropriate use of equipment and devices will be identified as part of the hazard assessment and analysis. Interventions will be accompanied by communication with staff and leadership, residents, family and visitors. A quarterly assessment for Resident #4, dated 05/11/26, showed the resident had a BIMS score on 8 which indicated the resident was moderately impaired in cognition. The assessment showed Resident #4 had diagnoses which included generalized muscle weakness, cognitive communication deficit, and history of traumatic brain injury. The assessment showed Resident #4 had lower extremity impairments on both sides, used a wheelchair to ambulate, required substantial to maximal assist with bed mobility, and was dependent for bed to chair transfers. A discharge summary hospital record for Resident #4, dated 06/29/26, showed the resident was diagnosed with closed bicondylar fracture of the right femur from a witnessed fall. Physician orders for Resident #4, dated 07/06/26, showed the resident had orders for oxycodone (narcotic medication) HCl 5 mg every six hours for pain as needed and morphine tartrate (narcotic medication) oral tablets 25 mg two times a day. A final incident report, dated 07/09/26, showed Resident #4's legs were contracted and required the use of a mechanical lift to transfer. The report showed on 06/27/26, two CNAs had been assisting Resident #4 without the use of a mechanical lift to transfer the resident from the bed to a wheelchair. The report showed Resident #4 had been assisted to sit on the side of the bed by two CNAs. The report showed CNA #1 and CNA #2 held the resident's arms and assisted the resident to a standing position without (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 375347	Facility ID: 375347 If continuation sheet Page 1 of 5

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the use of a mechanical lift. The report showed Resident #4 was unable to bear weight and was lowered to the resident's knees. The report showed Resident #4 was transported to the emergency room, had x-rays, and was diagnosed with a closed bicondylar fracture of the right femur which required surgery. The report showed the family representative refused surgery and the resident's pain was managed with medications. On 07/21/26 5:52 p.m., Resident Representative #1 stated Resident #4's leg was broken after the fall, and they refused the suggested surgery because the resident would refuse after care. Resident Representative #1 stated Resident #4 had cognitive impairments and would tell staff frequently they could perform ADLs outside their assessed ability. On 07/22/26 at 10:09 a.m., CNA #1 stated Resident #4 seemed cognitive and had informed CNA #1 and CNA #2 they could transfer without the use of a mechanical lift. CNA #1 stated they were a new employee and had never worked with the residents on that hall. They stated they did not know the resident's needs and the charge nurse had not informed the CNAs that Resident #4 required a mechanical lift to transfer. CNA #1 stated CNA #2 and themselves had assisted Resident #4 to transfer from the bed to a wheelchair by holding the resident's arms on each side. CNA #1 stated when Resident #4 was shifting to the wheelchair from the bed after standing, the resident's knees could not bear the weight, and the resident was lowered to the resident's knees. CNA #1 stated LPN #3 was notified and assessed the resident. CNA #1 stated CNA #2 and LPN #3 assisted Resident #4 without a lift off of the resident's knees and into a wheelchair. CNA #1 stated Resident #4's knees were red, the resident complained of pain, and an x-ray was ordered later in the evening. On 07/22/26 at 10:29 a.m., CNA #2 stated they had assisted CNA #1 with transferring Resident #4 from the bed to a wheelchair without the use of a mechanical lift. CNA #2 stated they had not checked the care plan for Resident #4 prior to assisting the resident for appropriate interventions for transfers. CNA #2 stated CNA #1 and CNA #2 got on each side of Resident #4, held the resident's arms, and assisted the resident to stand from the side of the bed when Resident #4 fell to the resident's knees. CNA #2 stated LPN #3 assessed Resident #4 and CNA #1, CNA #2, and LPN #3 assisted the resident to the wheelchair from the resident's knees without a lift. CNA #2 stated Resident #4 was complaining later in the evening of right knee pain and was sent out for an x-ray. CNA #2 stated they knew they had made a mistake because Resident #4 required two persons and a mechanical lift to transfer. CNA #2 stated they should have checked Resident #4's care plan to see what interventions the resident required to transfer. On 07/22/26 12:58 p.m., the DON stated the CNA #1 and CNA #2 had not looked at Resident #4's care plan which showed the resident required two people and a mechanical lift to transfer. The DON stated CNA #1 and CNA #2 attempted to transfer Resident #4 from the bed to a wheelchair without the use of a mechanical lift which resulted in the resident falling to the resident's knees. The DON stated Resident #4 had to be sent to the hospital and was diagnosed with bruising on the left leg and a fracture to the right femur. The DON stated the CNAs should not have listened to Resident #4 who told the aides the resident could transfer without a lift because the resident's cognition was impaired. On 07/22/26 at 5:44 p.m., LPN #3 stated CNA #1 and CNA #2 transferred Resident #4 without the uses of a mechanical lift because CNA #1 was new and CNA #2 did not know the resident. LPN #3 stated Resident #4 had told the CNAs the resident could stand. 2. On 07/21/26 at 10:26 a.m., the water temperature in the sink in room [ROOM NUMBER] was observed to be 128.4 F. On 07/21/26 at 10:28 a.m., the water temperature in the sink in room [ROOM NUMBER] was observed to be 132 F. On 07/21/26 at 10:30 a.m., the water temperature in the sink in room [ROOM NUMBER] was observed to be 132.4 F. On 07/21/26 at 10:31 a.m., the water temperature in the sink in room [ROOM NUMBER] was observed to be 128.9 F. On 07/21/26 at 10:40 a.m., the water temperature in the sink in room [ROOM NUMBER] was observed to be 128.7 F. On 07/21/26 at 10:41 a.m., the water temperature in the sink in room (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER McLoud Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0689 Level of Harm - Actual harm Residents Affected - Few	[ROOM NUMBER] was observed to be 128 F. On 07/21/26 at 10:43 a.m., the water temperature in the sink in room [ROOM NUMBER] was observed to be 126.3 F. On 07/21/26 at 11:16 a.m., the water temperature in the shower room on the north hall was observed to be 135 F. A document from the Consumer Product Safety Commission titled Avoiding Tap Water Scalds, undated, showed keeping hot water at the tap no higher than 120 F. was suggested to significantly reduce the risk of scald burns, especially for children, the elderly, and people with reduced mobility. The document showed burns could occur with exposure to water temperatures in excess of 130 F. within 30 seconds. A policy titled Water Temperature, Safety of, revised 12/2009, read in part, Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures no more than 110 F, or the maximum allowable temperatures per state regulation. A quarterly assessment for Resident #30, dated 07/21/26, showed the resident had a BIMS score of 15 which indicated the resident's cognition was intact. The assessment showed Resident #30 had diagnosis which include peripheral vascular disease and congestive heart failure. On 07/24/26 at 10:09 a.m., Maintenance #1 stated they checked the water temperatures daily and water should not have been beyond 100 F. They stated the water temperature was high on the previous day, so they adjusted the temperature. On 07/21/26 at 10:43 a.m., Resident #30 stated the water in their room got hot immediately and they had to be careful to avoid being burned. On 07/21/26 10:58 a.m., Maintenance #1 stated residents' skin could have been scorched, scalded, or burned. Maintenance #1 stated there were 10 rooms that were exceeding water regulation temperatures.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff were educated on how to access care plans for 1 (CNA #1) of 5 sampled staff reviewed for competent nursing staff. The DON identified 47 staff provided direct care to the residents. Findings: On 07/21/26 at 5:17 p.m., Resident #4 was observed in a geriatric chair with a mechanical lift sling under the resident in the dining room. A care plan for Resident #4, dated 04/04/19, showed the resident required extensive assistance with ADL care. The care plan showed Resident #4 used a mechanical lift to transfer and two staff to assist in the transfers. A Nurse [NAME] Qualifications and Training Requirements, policy revised 05/2019, read in part, 5. Our facility will not use any individual as a nurse aide who has worked less than four months unless the individual a. Is a full-time employee participating in a state-approved training and competency evaluation program; or B. Has demonstrated competence through satisfactory participation in the state approved, nurse aid, training, and competency evaluation program; .6. Applicants who meet the qualifications for a nurse aide and are in training will have a minimum of 16 hours of training in the following area prior to direct contact with the residents; .(8) Transfers, positioning, and turning, .(2) Use of assistive devices in transferring, ambulation, eating, and dressing; A policy titled Using the Care Plan, dated 06/2024, read in part, The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have the responsibility for providing care and services to the resident. A [name withheld] Nursing Center New Hire Checklist for CNA #1 dated 06/12/26, showed skills Checklist Completed (if applicable) was not checked off as completed. A Nursing Assistant Skills Review Checklist for CNA #1, dated 06/13/26, showed CNA #1 was hired on 06/12/26. The checklist, read in part, Directions: Participant identified knowledge of topic by entering 1, 2 or 3 in the Self-Evaluation column for each topic area prior to meeting with facilitator. Facilitator enters the date when skills are reviewed and when validation/return demonstration is completed and then adds signature in the adjoining column. The checklist showed CNA #1 did not self-evaluate the skill of Computer use/Fax/ Copier Use and Reports: 24 hour/Stand up/Shift to Shift. The skills check list did not show the date when the skills were reviewed and when validation/return demonstration was completed on any of the skills. The checklist did not show the date the DON signed off the skills check had been completed. A quarterly assessment for Resident #4, dated 05/11/26, showed the resident had a BIMS score on 08 which indicated the resident was moderately impaired in cognition. The assessment showed Resident #4 had diagnoses which included generalized muscle weakness, cognitive communication deficit, and history of traumatic brain injury. The assessment showed Resident #4 had lower extremity impairments on both sides, used a wheelchair to ambulate, required substantial to maximal assist with bed mobility, and was dependent for bed to chair transfers. A final incident report, dated 07/09/26, showed Resident #4's legs were contacted and required the use of a mechanical lift to transfer. The report showed on 06/27/26, two CNAs had been assisting Resident #4 without the use of a mechanical lift to transfer from the bed to a wheelchair. The report showed Resident #4 had been assisted to sit on the side of the bed by two CNAs. The report showed CNA #1 and CNA #2 held the residents' arms and assisted the resident to a standing position without the use of a mechanical lift. The report showed Resident #4 was unable to bear weight and was lowered to the residents' knees. The report showed Resident #4 was transported to the emergency room, had x-rays, and was diagnosed with a closed bicondylar fracture of the right femur which required surgery. The report (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed the family representative refused surgery and the resident's pain was managed with medications. On 07/22/26 at 10:09 a.m., CNA #1 stated Resident #4 seemed cognitive and informed CNA #1 and CNA #2 they could transfer without the use of a mechanical lift. CNA #1 stated they had never worked with the residents on that hall, was new employee, did not know the resident's needs, was not trained on how to access the care plan, and the charge nurse did not inform the CNAs the resident required a mechanical lift to transfer. On 07/22/26 at 5:13 p.m., the DON was asked about skills review check list for CNA #1. The DON stated the CNAs worked through nursing assistance skill review check list, keep it with the CNA during their shift, and the nurse watched these skills, and they signed off on the list. The DON stated they signed off on 06/30/26 showing CNA #1 was trained on the mechanical lift. The DON stated nurses told them and they did not know name of nurse or the date, but they did sign off CNA #1 passed the skills check list. The DON stated they were not sure when CNA #1 skills were reviewed and/or demonstrated. On 07/22/26 at 5:44 p.m., LPN #3 stated CNA #1 and CNA #2 transferred Resident #4 without the use of a mechanical lift because CNA #1 was new.		