STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375372	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Choctaw Nation Nursing Home	400 Southwest O Street Antlers, OK 74523

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure a resident was not prescribed an antipsychotic medication for a diagnosis of Alzheimer's disease for 2 (#8 and #18) of 5 sampled residents reviewed for unnecessary medications. The ADON stated there were 6 residents prescribed antipsychotic medications at the facility. Findings: A facility policy titled Antipsychotic Medication Use, dated July 2022, read in part, Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated. 1. A physician's medication order for Res #8, dated 06/02/25, showed the resident had an order for Quetiapine [an antipsychotic medication] 25 mg at bedtime for the diagnosis of unspecified dementia, mild, with other behavioral disturbance. On 06/17/25 at 3:49 p.m., the DON reviewed Res #8's order for Quetiapine and stated the resident was being administered and antipsychotic medication. They stated the resident did not have a diagnosis that was approved for the use of Quetiapine. They stated the resident had been admitted to the facility with that diagnosis for that medication. 2. A physician's medication order for Res #18, dated 08/14/24, showed the resident had an order for Quetiapine [an antipsychotic medication] 12.5 mg at bedtime for the diagnosis of Alzheimer's disease, unspecified. 06/17/25 at 11:35 a.m., the DON was asked to define what Quetiapine was and its uses. They stated it was a medication used for such things as hallucinations and had serious side effects. They stated it was used for specific mental health diagnoses and was not to be used for people diagnosed with dementia. They stated Res #18's order was supposed to have been changed. They stated Res #18 was taking Quetiapine because they take their belt off and try to hit people with it. They stated they did not know why the resident did that, but they would meet with the physician and pharmacist to see what would be appropriate for the resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interview, the facility failed to ensure an annual assessment had been completed in the time frame required for 1 (#12) of 5 sampled residents reviewed for MDS assessments. The administrator stated 27 residents at the facility required MDS assessments. Findings: A facility policy titled Resident Assessment Instrument, dated October 2010, read in part, The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change in the resident's condition; c. At least quarterly; and d. Once every twelve (12) months. On 06/17/25 at 3:36 p.m., Res #12's EMR was reviewed for MDS assessments. In the MDS section, a list of assessments and their status showed Res #12's annual assessment, dated 04/15/25, was still in progress. On 06/18/25 at 8:50 a.m. the administrator stated the former MDS coordinator had quit suddenly, and the facility did not have another person trained to perform the duties of that office until about one week prior to this survey. They stated they understood Res #12's annual assessment had not been completed in the required time frame. On 06/18/25 at 8:53 a.m., the regional director of operations #1 stated the corporation had two MDS coordinators from two facilities quit about the same time, so they did not have anyone available to immediately come to this facility. They stated they have recently trained someone, and they will catch up on past due assessments including Res #12's annual assessment.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure there was RN coverage 8 hours/day, 7 days/week. The DON identified 27 residents resided in the facility. Findings: A PBJ Staffing Data Report, dated 01/01/25 through 03/31/25 [the second quarter of fiscal year 2025], showed the facility did not have RN coverage on 9 of the 90 days in that quarter. The dates identified on the PBJ report as not having RN coverage in January, February, and March 2025 were 01/06/25, 01/13/25, 01/14/25, 01/27/25, 02/03/25, 02/11/25, 02/12/25, 02/17/25, and 03/31/25. A facility document titled Time Detail Report, dated 01/01/25 through 03/31/25, showed there was not a registered nurse on duty on 01/06/25, 01/13/25, 01/14/25, 01/27/25, 02/03/25, 02/11/25, 02/12/25, 02/17/25, and 03/31/25. On 06/17/25 at 2:08 p.m., the regional director of operations #2 stated they had reviewed their staffing records and found the PBJ report for the facility, for the first quarter of 2025, was accurate. They stated the facility had not had an RN on duty on 01/06/25, 01/13/25, 01/14/25, 01/27/25, 02/03/25, 02/11/25, 02/12/25, 02/17/25, and 03/31/25.