STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375378	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Oaks Care Center	1401 4th Street Pawnee, OK 74058

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a discharge summary which included a recapitulation of the resident's stay and follow-up instructions were completed for 1 (#64) of 2 sampled residents who were reviewed for discharges.The DON identified one resident who had been discharged to another facility in the last three months.Findings: An undated diagnoses list showed Res #64 admitted to the facility on [DATE] with diagnoses of hypertension, chronic obstructive pulmonary disease, hyperlipidemia, and renal insufficiency. A quarterly assessment, dated 11/05/25, showed Res #64's cognition was moderately impaired with a BIMS score of 10. A discharge assessment dated [DATE], showed the resident discharged to an inpatient rehab facility on 12/26/25. A review of the resident's chart did not show a discharge summary. On 03/19/26 at 3:07 p.m., MDS #1 stated there was no discharge summary completed.

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 - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to ensure assessments were completed for discharge for 1 (#39) of 1 sampled resident reviewed for resident assessments.The DON identified 57 residents resided in the facility.Findings:An undated face sheet, dated 11/13/25, showed Res #57 admitted to the facility. A nurse note, dated 11/14/25, showed Res #57 discharged home against medical advice. An entry assessment was completed and submitted on 11/16/25. A Medicare 5-day assessment was completed on 11/19/25. A review of the resident's chart did not show a discharge assessment had been completed. On 03/19/2026 at 3:04 p.m., MDS #1 stated a discharge assessment should have been completed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a baseline care plan was completed for 1 (#32) of 15 sampled residents reviewed for baseline care plans.The administrator identified 57 residents resided in the facility.Findings:On 03/17/26 at 11:51 a.m., Res #32 observed in his bed. Res #32 voiced he had been in the facility a few weeks.An undated facility policy titled, Care Plans - Baseline, read in part, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. A Care Plan Report, dated 03/15/26, showed Res #32 was admitted to the facility on [DATE]. The report showed the baseline care plan was initiated on 03/15/26.On 03/17/26 at 11:51 am., Res #32 voiced he had been in the facility a few weeks.On 03/20/26 at 10:04 a.m., the DON stated Res #32 was admitted on [DATE] and did not have a 48 hour care plan until 03/15/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan included interventions for behaviors for 1 (#37) of 15 sampled residents whose care plans were reviewed.The DON identified 57 residents resided at the facility. Findings: On 03/17/26 at 11:14 a.m., Res #37 was observed sitting in a chair beside the bed. There was a strong odor of urine in the room. An admission form, dated 05/21/26, showed Res #37 had diagnoses which included dementia and depression. A care plan, dated 05/28/25 did not show interventions for behaviors. A behavior note, dated 02/26/26 at 9:35 p.m., read in part, What was the behavior?: resident is aggressive when asked about showersDid anything worsen the behavior?: yes, asking her to get up.What was the resident doing just prior to the onset of the behavior?: sleepingWhat non-pharmacological approaches were attempted to reduce/resolve the behavior?: tried to explain the importance of a showerWhat were the results of the non-pharmocological interventions?: naDid the behavior resolve?: yesWhat interventions are in place to prevent a recurrance?: naWas there a medical or physical cause for the behavior?: dementiaWhat there a psycosocial reason for the behavior?: dementiaWas there an environmental reason for the behavior?: noWhat there a medication reason for the behavior?: dementiaHas delerium been ruled out as a cause for the behavior?: yesWas the physician notified?: noWas the family/responsible party notified?: noA quarterly assessment, dated 03/03/26, showed the Res was moderately impaired in cognition for daily decision making with a BIMS score of 11.On 03/19/26 at 12:45 p.m., CNA #1 stated Res #37 frequently refused showers and would get agitated when asked to shower. CNA #1 stated would attempt two or three times to get Res #37 to shower and if they were unsuccessful they notified the charge nurse. On 03/19/26 at 12:50 p.m., CNA # 2 stated Res #37 could be hateful. CNA #2 stated they attempted to give Res #37 a shower, but they often refused. CNA #2 stated if the Res refused more than three times they notified the charge nurse who documented it in the progress notes.On 03/19/26 at 12:50 p.m., CNA #3 stated at times Res #37 would not get out of bed and would not allow staff to change their brief or shower them. CNA #3 stated they attempt two or three times to shower Res #37 and if they still refused, they notify the charge nurse. On 03/19/26 at 12:55 p.m., LPN #3 stated if Res #37 refused to shower the CNA's reported this to them and they would attempt to get the resident to shower. LPN #3 stated if they could not get Res #37 to shower, they documented it in the progress notes.On 03/19/26 at 1:00 p.m., MDS coordinator #1 stated Res #37's behavior for agitation and refusing showers did not show in the care plan but it should have been care planned. They stated they needed help and could not keep up with the care plans.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to obtain a physician's order for a catheter for 1 (#55) of 1 sampled resident reviewed for catheters.The DON identified 57 residents resided in the facility.Findings:On 03/17/26 at 12:34 p.m., Res #55 was observed sitting in their wheelchair in the dining room. Res #55's catheter bag was observed attached to the side of the wheelchair in a privacy bag. On 03/18/26 at 10:13 a.m., Res #55 was observed sitting in their wheelchair in their room. Res #55's catheter was observed hanging on the side of their wheelchair draining to gravity. The catheter bag was observed inside a privacy bag. An undated diagnoses list showed Res #55 admitted to the facility with diagnoses which included retention of urine, acute kidney failure, and benign prostatic hyperplasia. An admission assessment, dated 02/15/26, documented the resident had an indwelling catheter. A care plan, revised 02/20/26, showed the resident had an indwelling catheter. A review of the resident's record did not show a physician's order for the catheter. On 03/19/2026 at 3:09 p.m., the DON stated there should have been a physician order for the catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to change and store nebulizer tubing in a sanitary manner for 1 (#4) of 3 sampled residents who were reviewed for respiratory care.The DON identified 57 residents resided in the facility.Findings:On 03/17/26 at 11:00 a.m., Res #4 was observed sitting in a recliner in their room. A nebulizer mask and tubing were observed lying on a sheeted bed mattress directly behind the resident.On 03/18/26 at 10:20 a.m., Res #4 was observed sitting in a recliner in their room. A nebulizer mask and tubing were observed lying on a sheeted bed mattress directly behind the resident.On 03/19/26 at 12:45 p.m., a nebulizer mask and tubing were observed lying on a sheeted bed mattress directly behind Res #4's recliner.An undated medical diagnoses list for Res #4 showed the resident admitted with diagnoses which included simple chronic bronchitis and acute respiratory failure with hypoxia.An Administering Medications through a Small Volume (handheld) Nebulizer policy, revised 10/2010, read in part, Rinse and disinfect the nebulizer equipment according to facility protocol.When equipment is completely dry, store in a safe and sanitary manner.Change equipment and tubing every seven days, or according to facility protocol. A physician order, dated 02/04/26, showed budesonide (anti-inflammatory medication) 0.5 mg/2 milliliters via nebulizer one time a day for shortness of breath.An admission assessment, dated 02/15/26, showed the resident was moderately cognitively impaired with a BIMS score of 12. The assessment showed the resident had no shortness of breath and received respiratory therapy. There were no documented nebulizer mask or tubing changes in the medical record.On 03/17/26 at 11:01 a.m., Res #4 stated they had received breathing treatments with the nebulizer intermittently. Res #4 stated they could not remember if they had received a breathing treatment that day.On 03/18/26 at 10:21 a.m., Res #4 stated they thought the staff had administered a breathing treatment with the nebulizer that morning.On 03/19/26 at 12:50 p.m., LPN #1 was shown Res #4's nebulizer mask and tubing lying on the sheeted mattress. LPN #1 stated the nebulizer equipment was not stored properly. LPN #1 stated the nebulizer mask and tubing should have been stored in a sealed plastic bag after use.On 03/19/26 at 12:55 p.m., LPN #1 was asked when Res #4's nebulizer mask and tubing had been changed. LPN #1 stated they weren't sure because the current tubing had not been labeled and dated. On 03/19/26 at 12:59 p.m., the IP stated the nebulizer mask and tubing should have been stored in a plastic bag to ensure proper infection control. The IP stated they were not sure of the policy but thought the tubing should be changed every 48-72 hours. The assistant director of nursing stated the tubing should have been documented as changed in a progress note or on the treatment administration record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure pharmacy recommendations were addressed by the physician for 1 (#3) of 5 sampled residents who were reviewed for unnecessary medications.The DON identified 57 residents who receive medications in the facility.Findings:An undated diagnosis list showed Res #3 admitted to the facility with diagnoses which included schizophrenia, anxiety, and depressive disorders. The Consolidated Report from Consultant Pharmacist, dated 11/05/25, read in part, Sertraline 100 mg daily - may we trial a reduction to 50 mg daily. The consultant pharmacist report was not addressed by the physician. On 03/19/26 at 3:15 p.m., the DON stated the physician should have answered the report within 30 days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was maintained in a sanitary manner for 1 (#19), of 2 sampled residents reviewed for oxygen therapy.The DON identified 57 residents resided in the facility. Findings: On 03/18/26 at 9:39 a.m., Res #19 was observed to not use oxygen. The oxygen tubing was observed to be lying on the floor next to Resident #19's bed. On 03/19/26 at 3:10 p.m., Res #19 was sitting in their wheelchair watching television. Res #19's oxygen tubing was observed to be lying on the floor. An undated admission record showed Res #19 had diagnoses which included peripheral vascular disease and dementia. A quarterly assessment, dated 12/18/25, showed the Res was cognitively intact with a BIMS score of 13. An undated policy titled Oxygen Administration, read in part, 8. Keep the oxygen cannula and tubing used PRN [as needed] stored in a clean manner (off the floor). On 03/19/26 at 3:15 p.m., Res #19 stated the staff did not put the oxygen tubing in a plastic bag. On 03/20/26 at 10:02 a.m., infection preventionist #1 stated oxygen tubing should not be on the floor. Infection preventionist stated it should be stored in a plastic bag on the wall. They stated they did not know why it was on the floor.