STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375420	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Okemah Care Center	112 North Woody Guthrie Okemah, OK 74859

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview, the facility failed to ensure oxygen (O2) tubing was labeled and dated for two, (26, and #36) of four residents sampled for respiratory care.The DON identified four residents that received oxygen therapy.Findings : On 02/23/26 at 12:35 p.m., Resident #26 was observed using oxygen tubing with a label dated 02/13/26. On 02/24/26 at 2:16 p.m., Resident #36 was observed using oxygen tubing with no label and without a date. An undated, Oxygen Concentrator Maintenance, read in part, All tubing will be changed weekly and PRN as needed for soiling. Tubing will be dated and initialed when completed.On 02/23/26 at 1:20 p.m., LPN #1 confirmed Resident #26 did use the oxygen and the label on the tubing was dated 02/13/26. They stated they thought it was to be changed out weekly.On 02/25/26 at 11:06 a.m., LPN #1 confirmed Resident #36 did use oxygen and there was not a label on the oxygen tubing. They stated they did not know when it had been changed.On 02/25/26 at 1:30 p.m., the DON stated the oxygen tubing should be changed out weekly, and it should be labelled and dated.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, and interview, the facility failed to ensure the temperature log was maintained for one of one medication refrigerators observed for proper temperature controls for medication storage. The administrator identified 42 residents resided in the facility. Findings:On 02/24/26 at 1:50 p.m., a tour of the medication room was conducted with CMA #1. The temperature log sheet for the month of February 2026, located on the front of the medication refrigerator, showed no documentation for 02/20/26, 02/21/26, 02/22/26, and 02/23/26. The refrigerator was observed to be 42 degrees Fahrenheit.A Medication Storage in the Facility policy, dated 5/2025, read in part, Medications requiring refrigeration or temperatures between 36 degrees F and 46 degrees F are kept on a refrigerator with a thermometer to allow daily temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label.On 02/25/2026 at 9:45 a.m., the DON stated the night shift is assigned to complete the temperature checks and documentation. They stated have had issues with the log sheet being completed in the past. The DON stated it should be done daily.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview the facility failed to: a. Discard gloves and gown after exiting and returning to the resident room after catheter care. b. Ensure staff changed gloves and wore a gown during wound care for 2 (#2 and #35) of 2 sampled residents reviewed for enhanced barrier precautions. The administrator identified nine residents with enhanced barrier precautions. Findings: 1. On 02/25/26 at 11:50 a.m., LPN #1 obtained supplies to complete catheter care for Resident #2. LPN #1 donned a gown and a pair of gloves. Catheter care was completed. The LPN #1 exited the room with the soiled washcloths and emesis basin of soapy water still wearing the gown and gloves used when care was provided. LPN #1 discarded the soapy water, five rooms down the hall, in a resident common bathroom. LPN #1 continued further down the hall to place the dirty linen in the dirty linen hopper. As LPN #1 walked down the hall to return to the resident room, they removed their gown and gloves and placed them in the trash can in the room of Resident #2. An ENHANCED BARRIER PRECAUTIONS POLICY AND PROCEDURE policy, dated 04/01/24, read in part, EBP WILL BE USED FOR RESIDENTS WITH INDWELLING MEDICAL DEVICES, WOUNDS, OR THOSE WHO ARE COLONIZED BY OR INFECTED WITH A MULTIDRUG - RESISTANT ORGANISM .3. CORRECTLY PUT ON A GOWN AND GLOVES 4. AFTER CARE, THROW AWAY GOWN AND GLOVES 5. CLEAN HANDS AGAIN. An annual assessment, dated 12/08/25, showed Resident #2 had diagnoses which included renal insufficiency, diabetes, and depression. The assessment showed Resident #2 had an indwelling catheter. The care plan, dated 01/09/26, showed Resident #2 had a supra-pubic catheter related to a neurogenic bladder and received catheter care every shift. The care plan showed Resident #2 was placed on enhanced barrier precautions related to the resident having a catheter. On 02/25/26 at 12:14 p.m., the administrator stated LPN #1 should not have entered the hall wearing the gown and gloves worn when catheter care was provided for Resident #2. On 02/26/26 at 10:04 a.m., the infection preventionist stated LPN #1 should not have exited the room wearing the PPE worn during resident care. The infection preventionist stated LPN #1 did not follow enhanced barrier precautions. 2. On 02/26/26 at 10:05 a.m., LPN #1 was observed to provide wound care to Resident #35. LPN #1 was not observed to change gloves between removal of soiled dressings, wound care, and application of clean dressings. They were not observed to don a gown prior to completing wound care. On 02/26/26 at 10:23 a.m., LPN #1 stated they should have changed gloves and performed hand hygiene in-between removing the soiled dressings and doing wound care, and they should have worn a gown for enhanced barrier precautions. On 02/26/26 at 10:37 a.m., the infection preventionist stated enhanced barrier precautions were not followed during the wound care observation. They stated this included glove changes, hand hygiene and wearing a gown.