

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Woodlands Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 East 6th Street Okmulgee, OK 74447	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, the facility failed to ensure residents were provided the opportunity to vote and provide activities for 3 (#2, 6, and #7) of 3 sampled residents reviewed for resident rights. The administrator identified 54 residents resided in the facility. Findings: A facility document titled RESIDENT'S RIGHTS AND CONFIDENTIALITY, revised 08/01/17, read in part, At the facility, we recognize the importance of protecting and promoting the rights of all its residents. The right to civil and religious liberties. The right to participate in social, religious and group activities of choice. An activities calendar posted in a resident common area showed activities for 05/2026. A facility form titled Grievances, dated 06/2026, showed on 06/09/26 a specific concern regarding voting. 1. An undated admission record showed Resident #2 had diagnoses which included acute and chronic respiratory failure with hypoxia, chronic pain, and diabetes mellitus. A quarterly assessment for Resident #2, dated 02/25/26, showed the resident had a BIMS score of 15 and was not cognitively impaired. On 06/18/26 at 3:55 p.m. Resident #2 stated the facility did not provide activities for the residents. Resident #2 stated if an activity was scheduled it was usually cancelled. Resident #2 stated they did not get to vote last week on the 15th because the activities staff failed to complete the required documentation. 2. An undated admission record showed Resident #6 had diagnoses which included major depressive disorder and history of falls. An annual assessment for Resident #6, dated 04/21/26, showed the resident had a BIMS score of 15 and was not cognitively impaired. On 06/19/26 at 3:47 p.m. Resident #6 stated the facility did not have scheduled activities. Resident #6 stated they were unable to vote last week because the activities staff failed to complete the required paperwork. 3. An undated admission record showed Resident #7 had diagnoses which included chronic obstructive pulmonary disease, parkinsonism, and diabetes mellitus. An annual assessment for Resident #7, dated 05/16/26, showed the resident had a BIMS score of 15 and was not cognitively impaired. On 06/18/26 at 9:57 a.m., Resident #7 stated they were upset because they did not get to vote in the election last week. Resident #7 stated the activities staff did not complete the paperwork to allow the resident to obtain an absentee ballot to vote. On 06/18/26 at 11:14 a.m., the administrator stated the activities staff had not completed the required paperwork in time to allow the residents to vote in the election last week. The administrator stated the activities staff was off on vacation until next week and there was no one providing activities in their absence.		

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to complete a thorough investigation for an allegation of neglect for 1 (#4) of 1 sampled resident reviewed for neglect. The administrator identified one allegation of neglect in the last six months. Findings: A facility policy titled Administrative Policies and Procedures Resident Abuse, Neglect and Misappropriation of Property, revised 11/01/22, read in part, A member of the administrative staff will then conduct a thorough investigation of the incident/allegation to obtain information about the incident and complete ODH [Oklahoma State Department of Health]-283. Thorough investigations may include interviewing relevant staff, residents, families and/or other witnesses, reviewing chart information and contacting the physician. An undated admission record showed Resident #4 had diagnoses which included acute respiratory failure with hypoxia and a pressure ulcer of the sacral region stage 2. An admission assessment for Resident #4, dated 03/30/26, showed the resident had a BIMS score of 15 and was not cognitively impaired. The assessment showed Resident #4 was incontinent and dependent on staff for toileting. An Oklahoma State Department of Health incident report form, dated 04/15/26, showed an allegation of neglect for Resident #4. The report showed Resident #4's family had reported the resident had been left in a soiled brief on two separate occasions. The report showed an undated and unsigned handwritten document with residents being asked if they had any concerns at that time. The report showed an investigation was completed. There were no documented staff, family, or physician interviews. On 06/22/26 at 12:30 p.m., the administrator reviewed the investigative documentation regarding the allegation of neglect for Resident #4. They identified the initials on the undated and unsigned handwritten document as resident initials. The administrator stated the residents were asked the question Do you have any concerns at this time? The administrator did not provide documented staff, family, or physician interviews.		