STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375497	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stigler Nursing & Rehab	1402 Northwest 7th Street Stigler, OK 74462

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 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 a RN was in the facility 08/2025 through 09/2025 at least eight consecutive hours a day, seven days a week.The administrator identified 54 residents resided in the facility. Findings: A PBJ [Payroll Based Journal] Staffing Data Report, dated 07/01/25 through 09/30/25, showed no RN hours on 08/25/25, 09/19/25, 09/24/25, and 09/25/25. A form titled DON TIME LOG, dated 08/2025, did not show the DON worked on 08/25/25. The DON stated they were considered the eight hour a day RN coverage Monday through Friday for the facility. A form titled DON TIME LOG, dated 09/2025, did not show the DON worked on 09/19/25, 09/24/25, or 09/25/25. The DON stated they were considered the eight hour a day RN coverage Monday through Friday for the facility. A nurse staff schedule for 02/2026 showed the DON was considered the eight hour a day consecutive RN coverage for the facility Monday through Friday. On 02/11/26 at 2:22 p.m., the DON reviewed the DON time log and stated they must have failed to sign the log when they worked on 08/25/25, 09/19/25, 09/24/25, and 09/25/25. The DON stated they were considered the eight hour a day RN coverage for those days.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided with advance directive information for 2 (#5 and #10) of 24 sampled residents reviewed for advance directives.The administrator identified 54 residents resided in the facility.Findings: A facility policy titled Health, Medical Condition and Treatment Options, Information Resident of, dated 12/2022, read in part, Residents will be informed of their health, medical condition and options for treatment and/or care.Right to formulate an advance directive upon admission and/or if the resident requests to complete an advance directive after admission. 1. A physician order tab in the electronic medical record showed Resident #5 was admitted to the facility on [DATE]. A review of the electronic health records for Resident #5 showed no advanced directive acknowledgement form. A physician order for Resident #5, dated 02/04/26, showed the resident's code status was do not resuscitate. On 02/11/26 at 1:30 p.m., the administrator stated a signed advance directive acknowledge form was not located for Resident #5. The administrator stated advanced directive information was provided and obtained with admission. The administrator stated the advance directive acknowledgement form for Resident #5 was not part of their clinical record. 2. An undated Advance Directive Acknowledgement form for Resident #10 was not marked to show the resident had executed an advanced directive or had not executed an advanced directive. The form did not have a signature by the resident or resident representative. On 02/10/26 at 9:27 a.m., the administrator stated Resident #10 had been at the facility for several years prior to the current staff managing the facility. On 02/10/26 at 10:47 a.m., the SSD stated no other documents for Resident #10 had been found regarding their advance directive or acknowledgement. On 02/11/26 at 8:04 a.m., the SSD stated they were unable to locate a signed copy of the advance directive or acknowledgement of advance directive for Resident #10.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to ensure residents who were discharged from Medicare Part A skilled services, had benefit days remaining, and remained in the facility were issued SNF ABN and NOMNC notices for 1 (#23) of 3 sampled residents reviewed for beneficiary notices. The MDS coordinator identified nine residents discharged from Medicare Part A skilled services with benefit days remaining in the past six months. Findings:A ''SNF Beneficiary Notification Review form, dated 02/10/26, showed Resident #23 was admitted to Part A skilled services on 10/23/25, discharged from Part A skilled services on 12/19/26, and remained in the facility. The form showed Resident #23 was not provided with a SNF ABN or NOMNC notice.On 02/10/26 at 12:55 p.m., the MDS coordinator stated SNF ABN and NOMNC notices were not provided to Resident #23 but should have been per regulations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure staff served food in a manner that would reduce the risk of cross contamination during one of one kitchen observation. The DM identified 53 residents received meals prepared by the kitchen and one resident who received nutrition via peg tube. Findings: On 02/11/26 at 12:00 p.m., meal service was observed. CNA #1 approached the kitchen window to obtain a meal prepared by the dietary staff. The dietary staff prepared a plate, desert dish, and drinks for the staff to transport to a resident's table. CNA #1 picked up the uncovered meal plate and the desert dish in each hand. There were two drink glasses remaining to be transported. CNA #1 picked up the glasses by the rims using their third, fourth, and fifth fingers of each hand and transported the meal the resident's table. CNA #2 approached the kitchen window to obtain another resident's meal. CNA #2 picked up the uncovered plate and placed the desert dish in the middle of the plate touching the food items. CNA #2 then picked up two drink glasses with the same hand by grasping one glass at the bottom of the glass using their thumb and first finger and grasping the other glass by the rim using their third, fourth, and fifth fingers and transported the meal the resident's table. An undated Food & Nutrition Infection Control policy, read in part, Never touch eating surfaces of plates, inside of bowls, rims of cups or glasses, or food-contact ends of utensils.Do not stack bowls on cups or glasses. On 02/11/26 at 12:02 p.m., CNA #1 stated they should have used a tray to transport the meal from the kitchen window to the residents' table and not handle the residents' glasses by the rims. On 02/11/26 at 12:03 p.m., CNA #2 stated they should not have placed the desert container on the residents' plate touching the food. CNA #2 stated the desert container that touched the food was an infection control concern. On 02/11/26 at 12:03 p.m., the DM stated the facility staff should have used a tray to transport the plate, desert, and drink glasses to the tables. The DM stated the staff should not have handled the glasses by the rim or place desert containers on plate in the food. On 02/11/26 at 12:10 p.m., the DON stated the staff should observe infection control practices when they transported meals to the residents. The DON stated the food containers should not have touched the food and staff should not have handled to glasses by the rims.

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure walls were kept clean for 1 (room [ROOM NUMBER]) of 1 room observed for infection control concerns.The administrator identified 54 residents resided in the facility. Findings: On 02/05/26 at 1:30 p.m., room [ROOM NUMBER] was observed. There was 3 to 4 inches of the base board pulled away from the bottom of the wall next to the bathroom door. There was a moderate amount of a black substance on the wall under and around the base board. On 02/05/26 at 1:40 p.m., housekeeper #1 stated they had worked at the facility for three months. Housekeeper #1 stated the black substance on the wall looked like mold. They stated it had been that way since they have worked at the facility. Housekeeper #1 stated they had tried to clean it off the wall several times, but it would not come off. On 02/11/26 at 10:46 a.m., the maintenance supervisor stated the black substance looked like mold. They stated they used spackling to adhere the base board back to the wall and around the skirting. They stated the spackling did not remove the mold, only covered it up. They stated it should have been cleaned off the wall.