STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375561	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Ann's Skilled Nursing and Therapy	9400 St Ann's Drive Oklahoma City, OK 73162

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to update a care plan for 1 (#14) of 22 sampled residents observed for accurate care plans. The DON identified 105 residents resided in the facility. Findings: On 06/12/25 at 1:37 p.m., Resident #14 was observed sitting up in bed at approximately a 75 degree angle and slowly feeding themselves. Most of their food was still on their plate. They stated, It would be nice if I had help. On 06/12/25 at 2:00 p.m., CNA #10 went in and asked if Resident #14 was done and then left the tray with them, but did not assist. A care plan, initiated on 10/06/21, showed Resident #14 required supervision or limited staff participation to eat. The care plan had not been revised. On 06/12/25 at 2:12 at p.m., CNA #10 stated, I don't know why [Resident #14] is in [their] room, I take care of the opposite side of the hall. I already went in there twice and [Resident #14] said [they were] fine. [Resident #14] is not a feeder as far as I know. We have a feeding table in the dining room for those that require assistance. [Resident #14] didn't get [their] tray until almost one o'clock. I'm not just going to leave [Resident #14] there, I am going to ask if [they] need help. I am the one that passed the trays, so it is my responsibility to make sure the residents on the hall get assistance if they need it, while CMA #3 is assisting in the dining room. On 06/12/25 at 2:18 p.m., CMA #3 stated, I believe [Resident #14] requires queuing and supervision. [Resident #14] did not want to go to the dining room for lunch today. We can look at the care plan to find out what kind of assistance they require if we don't know. On 06/12/25 at 2:25 p.m., the MDS coordinator stated, [Resident #14] had a significant change assessment done on 04/04/25 because their functional status had declined and they were picked up by hospice. The significant change assessment shows that [Resident #14] required substantial/maximal assistance with eating. The care plan shows [Resident #14] requires supervision or limited staff participation to eat. That part of the care plan was initiated on 10/06/21, and has not been revised since then. I am supposed to update care plans every time I complete a comprehensive assessment. I must have missed it. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/25 at 2:53 p.m., the administrator stated, Yes, care plans should be current and the expectation is that staff should assist when a resident requires assistance with eating.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to provide eating assistance for 1 (#14) of 1 sampled resident observed for eating assistance. The DON identified 105 residents resided in the facility and eight residents required feeding assistance. Findings: On 06/12/25 at 1:37 p.m., Resident #14 was observed sitting up in bed at approximately a 75 degree angle and slowly feeding themselves. Most of their food was still on their plate. They stated, It would be nice if I had help. On 06/12/25 at 2:00 p.m., CNA #10 went in and asked if Resident #14 was done and then left the tray with them, but did not assist. A Nursing Skills Guideline, revised 03/2025, read in part, Our facility is committed to providing care that respects the dignity, preferences, and unique needs of each resident. Assistance with activities of daily living will be provided in a manner that prioritizes the resident's comfort, safety, and personal preferences .To ensure care aligns with the principles of person-centered care, enhancing the quality of life and satisfaction of our residents. A significant change assessment, dated 04/04/25, showed Resident #14 required substantial/maximal assistance with eating and had a BIMS score of 10 indicating moderate cognitive impairment. On 06/12/25 at 2:12 at p.m., CNA #10 stated, I don't know why [they are] in [their] room, I take care of the opposite side of the hall. I already went in their twice and [they] said [they were] fine. [They are] not a feeder as far as I know. We have a feeding table. [They] didn't get [their] tray until almost one o'clock. I'm not just going to leave [them] there I am going to ask if [they] need help. I am the one that passed the trays, so it is my responsibility. On 06/12/25 at 2:53 p.m., the administrator stated, The expectation is that staff should assist when a resident requires assistance with eating.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure the 5 rights of medication administration to prevent medication errors for 1 (#257) of 22 residents reviewed for medication administration. The DON identified 105 residents resided in the facility. Findings: A policy titled Preparation for Medication Administration, revised 12/01/12, read in part, Medications are administered at the time they are prepared .Residents are identified before medication is administered. The medication nurse or certified medication aide will turn to that resident's medication sheet, compare photo with resident and positively identify the resident. An incident note, dated 06/02/25 at 10:45 p.m., read in part, Medication aide stated to nurse that [they] had made a mistake while attempting to administer medication. [They] state[d] that [they] had two patients who take their medication with applesauce. [They] prepared one cup of medication, applied applesauce and placed it in the cart to give a potassium tablet time to dissolve due to patient being unable to take it whole. [They] then prepared another patients medication and applied applesauce to it as well [they] then pushed [their] cart to [Resident #257's room] and gave the medication in the cup along with applesauce and when [they] returned to [their] cart [they] realized that the appropriate medication cup containing the potassium tablet was still in the cart dissolving. [They] immediately reported [their] findings to the nurse and the patients vitals were assessed right away. provider, family and management were all notified and medication aide was educated on the 5 rights on medication administration. Interventions to monitor vitals q [every] 2 are in place. On 06/10/25 at 11:06 a.m., LPN #6 stated, My med aide [CMA #6] reported that [they] had two different meds for residents in applesauce. One was potassium dissolving, I believe baclofen was the other that was inappropriately given. I educated [them] about the 5 rights of medication administration, notified the essential people, and initiated every two hour vital sign checks. I was noticing lower oxygen levels, I think it was [Resident #257's] baseline. There were no others symptoms. During my monitoring [Resident #257] was fine. Resident [#257] was on B hall at that time. The med aide [#6]worked down there quite often. On 06/10/25 at 3:15 p.m., CMA #6 stated, I was letting a resident's med melt in applesauce. I had another resident that also had to be crushed and added to applesauce.I usually use the PIG [punch, initial, give] method, and I check it three times. While the potassium was dissolving, I got [Resident #101's] baclofen because [they] asked for it while I was letting the potassium dissolve. I accidentally took the baclofen to [Resident #257] because I was getting [their] meds ready before I was asked to get [Resident #101's] medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/25 at 3:38 p.m., the DON stated, The nurse called me and let me know about the situation, I asked how [Resident #257] was, and if they had called the physician. I provided education to [LPN #6 and CMA #6] on the five rights of medication administration. The next day is when we started our in-service for the rest of the staff. We are scheduled to have our QA [quality assurance] meeting at the end of the month and the medication error will be addressed. We did already start monitoring medication administration with compliance rounds for five days, and then it will be weekly.