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	12/10/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure coordination of care with hospice services for 1 (#1) of 3 residents sampled for services per physician orders.The corporate nurse consultant identified 10 residents who received hospice services.Findings:A Hospice-Nursing Facility Contract, dated 07/08/25, read in part, Hospice and facility shall communicate with one another regularly and as needed for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of hospice patients are met 24 hours per day.An undated diagnosis report showed Res #1 had diagnoses which included Alzheimer's disease and dementia.A quarterly assessment, dated 10/25/25, showed Res #1 was severely cognitively impaired with a BIMS score of 00. The assessment showed Res #1 had no swallowing disorders and received hospice services.A nurse note, dated 11/04/25, showed Res #1 was declining in health with difficulty chewing and swallowing food and medications. The note showed hospice was contacted for reassessment.An undated hospice communication form showed Res #1 had been assessed by Hospice RN #1. Hospice RN #1 documented the physician would be contacted for a liquid antibiotic and pureed diet orders for Res #1. The form showed RN #2 had acknowledged receipt of the communication form.A hospice physician order fax form, dated 11/05/25, showed to administer cephalexin (an antibiotic) 500 mg every eight hours for seven days. The order form showed the facility received the fax on 11/11/25.A hospice physician order fax form, dated 11/10/25, showed to start a mechanical soft diet and may crush medications. The order form showed the facility received the fax on 11/11/25.A nurse note, dated 11/10/25, showed Res #1's family was upset due to the delay in antibiotic administration. The note showed hospice attempted to fax the physician orders multiple times unsuccessfully. The note showed verbal orders were received from hospice and initiated.An electronic physician order, dated 11/10/25, showed to start a pureed diet and crush medications.An electronic physician order, dated 11/11/25, showed to administer cephalexin 500 mg every eight hours for seven days for infection.A hospice communication form, dated 11/11/25, showed Res #1 had been assessed by Hospice RN #1. Hospice RN #1 documented Res #1's lung sounds and heart rate were improved and no signs/symptoms of pain were observed. The form showed RN #2 had acknowledged receipt of the communication form. A grievance form, dated 11/11/25, showed Res #1's family member voiced concerns regarding timeliness of diet change, medications being crushed, and receipt of hospice orders via fax.A QAPI form, dated 11/11/25, showed hospice orders implemented timely was identified as a problem. The form showed the immediate plan of correction was review of internal communication daily, staff in-service, and compliance rounds daily for 5 days, weekly for 4 weeks, and monthly for 2 months until compliance reached. A grievance resolution form, dated 11/14/25, showed the following interventions to prevent recurrence: hospice provider was contacted to change process of receiving orders. Hospice staff were to bring verbal orders sheets to place in residents' hospice binders instead of faxing orders to the facility,education provided to nurses regarding follow-up for changes made by hospice and/or physicians,in-service completed with staff, ombudsman notified, andreview of internal hospice communication daily.A Hospice in-service form, dated 11/14/25, showed staff were educated on follow-up, coordination of care, and ensuring family communication. A Sentinel Event Compliance Round Tracking form showed compliance rounds regarding hospice orders had been completed on 11/11/25, 11/12/25, 11/13/25, 11/14/25, 11/15/25, 11/17/25, 11/24/25, 12/01/25, and 12/08/25.On 12/08/25 at 2:35 p.m., RN #2 stated they received a communication form from the hospice nurse on 11/04/25 regarding Res #1. They stated the hospice nurse had communicated they would contact the physician and obtain orders for an antibiotic. RN #2 stated they had not realized the orders were not received until Monday 11/10/25 when Res #1's family member voiced concern regarding the delay in the initiation of the antibiotic. RN #2 stated they should have followed up with the hospice agency to ensure the orders had been received and initiated. RN #2 stated they had received education regarding the importance of follow-up for changes made by hospice and/or physicians. On 12/08/25 at 2:40 p.m., the ADON stated the staff noted a decline in Res #1 on 11/04/25 and notified hospice. They stated the hospice nurse assessed Res #1 and wrote on the communication form the physician would be contacted regarding a change in diet and an antibiotic for possible infection. The ADON stated the facility had not received the orders until 11/10/25 and 11/11/25. They stated RN #2 should have followed up with the hospice nurse within a few hours after the visit or reported to the oncoming nurse to follow up with the hospice nurse regarding the order