STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375566	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Crossing	811 West Elk Duncan, OK 73533

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 food was prepared and served in a sanitary manner that minimized the risk of infection/cross contamination during 2 of 2 meal preparation and service observations.The dietary manager identified 109 residents received nutrition from the kitchen. Findings:On 04/20/26 at 10:50 a.m., [NAME] #2 and a dietary aide were observed in the kitchen performing tasks without wearing beard guards covering their facial hair. The dietary aide was observed to scrub the sink and walls in the dish room. [NAME] #2 was observed to set up dishes and prepare the lunch meal. On 04/20/26 at 12:08 p.m., the following observations were made: a. [NAME] #1 was observed to prepare a sandwich using their bare hands, b. [NAME] #2 was observed to touch the ice scoop, cups, lids, straws, and plates while serving resident meals without washing their hands, and c. [NAME] #2 was observed to wear a beard guard but did not have a hair restraint over their mustache. A facility policy titled Food Safety and Sanitation, dated 2021, read in part, All staff will use safe food handling practices .Beard nets are required when facial hair is visible .Employees will wash their hands just before work and any time after they touch their face, hair, or other surfaces with potential for contamination. On 04/20/26 at 11:24 a.m., the dietary manager stated, They are supposed to wear guards. On 04/20/26 at 1:30 p.m., the dietary manager stated staff were supposed to avoid touching food with their ungloved hands. On 04/21/26 at 10:00 a.m., the registered dietician stated facial hair restraints and food handling was discussed often with dietary staff.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control practices were followed for residents with urinary catheters for 2 (#1 and #13) of 2 sampled residents reviewed for urinary catheters.The administrator identified two residents with urinary catheters resided in the facility. Findings:1. On 04/20/26 at 1:41 p.m., Resident #1 was observed being pushed into their room by a staff member. Resident #1's urinary catheter bag was observed to hang under their high-back wheelchair and drag on the floor.On 04/22/26 at 2:44 p.m., Resident #1 was observed lying in bed. Resident #1's urinary catheter bag was observed to hang from the bed frame and touch the floor.A care plan intervention for Resident #1, dated 07/07/20, showed the resident had a suprapubic catheter and was dependent on staff participation to maintain, such as cleaning and emptying.A quarterly assessment for Resident #1, dated 02/02/26, showed the resident's cognition was severely impaired with a BIMS score of six. The assessment showed Resident #1 had an indwelling urinary catheter and a diagnosis of obstructive uropathy.A physician's order for Resident #1, dated 04/05/26, showed to change the suprapubic catheter every month.On 04/22/26 at 2:45 p.m., LPN #1 stated Resident #1's urinary catheter bag should not touch the floor due to infection control concerns. 2. On 04/22/26 at 2:38 p.m., Resident #13 was observed in their wheelchair. The urinary catheter bag was observed to hang under the wheelchair and lay on the floor.A physician order for Resident #13, dated 04/16/26, showed urinary catheter care was to be provided every shift and as needed. A face sheet, dated 04/22/26, showed Resident #13 was admitted to the facility on [DATE] with a diagnosis of urinary retention.On 04/22/26 at 2:40 p.m., LPN #2 stated Resident #13's urinary catheter bag lying on the floor was an infection control issue. On 04/22/26 at 2:46 p.m., the DON stated urinary catheter bags in contact with the floor were an infection control concern.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the OSDH as required for 1 (#7) of 1 sampled resident reviewed for abuse. The administrator identified 109 residents who resided in the facility. Findings:The facility policy titled Reporting Abuse, revised 2014, read in part, It is the responsibility of our employees, facility consultants, physicians, family members, etc., to promptly report any incident of resident abuse to facility management .Staff members shall not knowingly withhold information from reporting agencies .Abuse investigations, reporting abuse to state agencies and other entities/individuals.A significant change assessment for Resident #7, dated 03/26/26, showed the resident had a BIMS score of15 indicating intact cognition. The assessment showed Resident #7 required moderate assistance with activities of daily living.An investigation report, dated 03/30/26, showed Resident #7 reported that an aide had slapped her. The report read in part, Upon immediate assessment and investigation, the statement was evaluated and determined not to constitute a credible allegation of abuse based on lack of specificity, absence of physical findings, and inconsistence observed with care and staff interaction. Therefore, it does not meet criteria for mandatory reporting under abuse regulations.A care plan for Resident #7, updated 04/06/26, showed the resident had impaired thought processes related to metabolic encephalopathy.On 04/21/26 at 12:24 p.m., Resident #7 stated about a month ago, a nurse aide slapped them while assisting with a shower. Resident #7 stated it was one of those traveling nurses. Resident #7 stated they still work here but they don't take care of me. Resident #7 stated they were not afraid for safety or retaliation.On 04/21/26 at 12:45 p.m., the DON stated an immediate investigation was initiated regarding the allegation of abuse for Resident #7. They stated they had determined the allegation was not substantiated. The DON stated the abuse allegation was not reported to the OSDH. On 04/22/26 at 9:38 a.m., CNA #3 stated a hospice aide had been assisting Resident #7 with a shower. CNA #3 stated they entered the shower room to inquire if the hospice aide needed help because Resident #7 had particular requests when finishing and would become agitated if a person did not meet their demands timely. CNA #3 stated they began assisting Resident #7 by untangling the oxygen tubing. CNA #3 stated when they bent down to unplug the oxygen concentrator, Resident #7 yelled you slapped me. CNA #3 stated the hospice aide was in the other part of shower room cleaning up and they were confused as to whom Resident #7 was referring to. CNA #3 stated they immediately reported the allegation of abuse to the DON.On 04/22/26 at 12:50 p.m., the DON and administrator provided an internal investigation report for the abuse allegation. The DON stated they should have sent the report to the OSDH.On 04/23/26 at 1:00 p.m., a family member of Resident #7 stated the facility had called them and reported Resident #7's allegation of being slapped by a staff member on the day it happened. The family member stated they observed Resident #7 daily for a week for any signs of bruising since the resident bruised easily. The family member stated Resident #7 made up the allegation of abuse because she got mad and didn't get her way. The family member stated the resident had a history of falsely accusing people of wrong doings.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop a baseline care plan for a urinary catheter for 1 (#13) of 2 sampled residents reviewed for urinary catheters.The administrator identified 2 residents with urinary catheters resided in the facility. On 04/22/26 at 12:50 p.m., Resident #13 was observed in their wheelchair with a catheter bag hanging under the wheelchair and lying on the floor.An undated policy titled Baseline Care Plan, showed the baseline care plan will include immediate care needs, activities of daily living assistance needs, and any required precautions or equipment.A baseline care plan for Resident #13, dated 04/15/26, contained no documentation of a urinary catheter. The baseline care plan showed Resident #13 required two or more staff assistance with toileting.A physician order for Resident #13, dated 04/16/26, showed urinary catheter to gravity, and catheter care every shift and as needed.A face sheet for Resident #13, dated 04/22/26, showed the resident was admitted to the facility on [DATE] with a diagnosis of urinary retention.On 04/22/26 at 9:52 a.m., CNA #1 and CNA #2 stated Resident #13 had the urinary catheter when they were admitted to the facility.On 04/22/26 at 2:45 p.m., the DON stated a catheter should have been included on Resident #13's baseline care plan.