STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375122	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Skilled and Nursing Therapy Norman	4554 West Main Norman, OK 73072

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was notified before there room was changed for 1 (#29) of 6 sampled residents reviewed for notification of room change. The administrator identified 104 residents resided in the facility. Findings: A facility document titled Oklahoma Resident Rights and Responsibilities, dated 11/29/22, read in part, 9. Every resident shall have the right to receive notice before the room or roommate of the resident is changed and if the resident has a telephone in his or her room, the resident must be informed of any charges to be incurred when moving. A facility document titled Census List [Resident #29], dated 11/25/25 through 01/25/26, showed Resident #29 was in room [ROOM NUMBER] on 12/15/25 at the time of discharge to a hospital. The document showed on 12/22/25 Resident #29 was in room [ROOM NUMBER]. An admission assessment for Resident #29, dated 12/02/25, showed the Resident #29 was admitted on [DATE] with diagnoses which included osteomyelitis and methicillin susceptible staphylococcus infection. The assessment showed Resident #29's cognition was fully intact with a BIMS score of 14. A discharge assessment for Resident #29, dated 12/15/25, showed Resident #29 discharged to a hospital for a short-term stay. On 01/28/26 at 10:02 a.m., Resident #29 stated they were hospitalized from [DATE] through 12/20/25. They stated their personal items were moved prior to them returning from the hospital. Resident #29 stated they did not receive any notification their room had been changed while they were in the hospital. On 02/02/26 at 9:59 a.m., LPN #2 stated when a resident's room was changed the resident should be notified. They stated a resident's room could be changed while they were in the hospital if the room was needed. LPN #2 stated Resident #29 was hospitalized from [DATE] through 12/20/25. They stated Resident #29's room was changed while they were in the hospital because they needed the bed for a resident of the opposite sex. On 02/02/26 at 10:32 a.m., the ADON stated they followed resident rights regarding room changes, and all cognitive residents should have been notified before a room was changed. The ADON stated on 12/15/25 there was no documentation in Resident #29's progress notes showing they were notified of the room change.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a bed hold policy was given to resident at the time of being discharged to the hospital for 1 (#29) of 6 sampled residents reviewed for bed hold policies given upon discharge.The administrator identified 104 residents resided in the facility. Findings: A facility policy titled Bed Hold Policy, dated 01/23/08, read in part, In the event the Resident is absent from the Facility temporarily for hospitalization or other leave, the Resident may request that the facility hold open the Residents bed during this time. This in known as a 'bed hold.' Resident shall be given notice of the bed hold option at the time of hospitalization or other leave. An admission assessment for Resident #29, dated 12/02/25, showed Resident #29 admitted on [DATE] with diagnoses which included osteomyelitis and methicillin susceptible staphylococcus infection. The assessment showed Resident #29's cognition was fully intact with a BIMS score of 14. A discharge assessment for Resident #29, dated 12/15/25, showed Resident #29 discharged to a hospital for a short-term stay. On 01/28/26 at 10:02 a.m., Resident #29 stated they were not made aware of the bed hold policy and did not receive a bed hold policy at the time of discharge on [DATE]. On 02/02/2026 at 9:42 a.m., LPN #1 stated when a resident was sent out to the hospital it was the case manager's responsibility to ensure a resident bed hold policy was provided to the resident. On 02/02/26 at 9:59 a.m., LPN #2 stated bed holds were handled by the nurses who sent the resident to the hospital. On 02/02/26 at 10:32 a.m., the ADON stated when a bed hold policy was provided to a resident it should be documented in the nurses' notes. The ADON stated Resident #29 went to the hospital on [DATE]. They stated there was no documentation showing a bed hold policy was given to Resident #29 in the nurse's notes on 12/15/25.

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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 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 clean dishes were stored in a sanitary manner during 1 of 1 observation of the storage of dishes in the kitchen.The DM identified 100 residents received nutrition from the kitchen. Findings: On 01/27/26 at 12:51 p.m., a crockpot was observed to be stained with an off-white coloring and food and dust. The crockpot was on the second shelf of a wire rack. A bowl was observed being used as storage for weighted silverware. The bottom of the bowl had dust and debris inside it. The bowl was located on the third shelf of the same wire rack. A Dry storage of Dishes and Utensils policy, revised 06/25/12, read in part, Clean and sanitized dishes and utensils will be stored in a clean and safe manner. On 01/27/26 at 12:55 p.m., the DM stated the crockpot was someone's personal crockpot and it should not have been stored there. The DM stated the bowl was dusty because they were not using the weighted silverware currently. The DM stated they would run the silverware and bowl through the dishwasher before using them. On 01/30/26 at 2:50 p.m., the DM stated the cleaning was supposed to be done daily but had not been completed for the past three days.