STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375151	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol Hill Skilled Nursing and Therapy	2400 Southwest 55th Street Oklahoma City, OK 73119

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and facility policy review, the facility failed to ensure the 2 (Dumpster #1 and Dumpster #2) of 3 dumpsters in the facility were kept covered at all times. This deficient practice had the potential to affect all residents who currently reside in the facility.Findings included: An undated facility policy titled, Safe Facilities and Pest Management, specified, Make sure the containers have tight-fitting lids and are kept covered at all times. During an observation of the facility garbage receptable area on 06/15/2026 at 9:02 AM, the surveyor noted there were three dumpsters and Dumpster #1 had no side door to close the dumpster and there was opened access to the trash located in the dumpster. The surveyor noted Dumpster #2 did not have a functioning lid, it was left opened and there were flying insects in and around both Dumpster #1 and Dumpster #2. During an observation of the facility garbage receptable area on 06/16/2026 at 12:49 PM with the Dietary Supervisor (DS) and the Regional Dietary Consultant (RDC), the surveyor noted Dumpster #2 had no side door, no functioning lid, and there were flying insects in and around the dumpster. During an interview on 06/16/2026 at 12:51 PM, the DS stated the dumpsters had been without a side door or functioning lid for about a year and a half. According to the DS, she informed the Administrator of the missing side doors and nonfunctional lid, but nothing had been done. The DS stated the Administrator she told was no longer employed with the facility. During an interview on 06/16/2026 at 12:53 PM, the RDC stated his expectation would be to have a garbage receptacle/dumpster with side doors and lid in place so that the dumpster could be securely closed. During an interview on 06/16/2026 at 1:51 PM, the Administrator stated her expectation was for the dumpsters to have an operating side door and top lid that could be closed. The Administrator acknowledged no one had been called to replace the dumpsters. During an interview on 06/19/2026 at 8:25 AM, Director of Nursing #1 stated she would expect the dumpsters to have functioning doors and lids to keep pests and weather away from the trash.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and document review, the facility failed to accommodate the needs for 1 (Resident #30) of 1 sampled resident who required a specialized call light. Findings included: On 06/16/2026 at 10:30 AM, the Administrator stated the facility did not have a policy regarding accommodation of residents' needs. A document titled, AliMed Worry-Free Pull-Cord Alarm, #72140 Instructions for Use and Care, indicated, A tug on the cord in any direction will cause magnetic sensor to release and alarm will be triggered. An admission Record revealed the facility admitted Resident #30 on 10/19/2025. According to the admission Record, the resident had a medical history that included diagnoses of dementia and hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2026, revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had an impairment on both sides in their upper extremities. Resident #30's Care Plan Report included a focus area revised 12/12/2025, that indicated admission / discharge plan miscellaneous. Interventions specified the resident's call light alternative was a clip alarm (initiated 05/11/2026). During a concurrent observation and interview on 06/15/2026 at 10:18 AM, Resident #30 stated they were supposed to have a call light in their hand. The surveyor did not observe a call light in Resident #30's hand. During a concurrent observation and interview on 06/15/2026 at 10:40 AM, Nurse Aide (NA) #13 stated Resident #30 was not able to use a regular call light, but the resident had a hand-held alarm. NA #13 located the pull-cord alarm and pinned it to Resident #30's clothing on the left chest area. Resident #30 attempted to reach for the pull-cord alarm and was unsuccessful. NA #13 then placed the pull-cord alarm without the string in Resident #30's right hand and left the resident's room. During an observation on 06/16/2026 at 11:35 AM and 11:43 AM, Resident #30's pull-cord alarm was pinned to the resident's left chest area and there was no string observed in the resident's hand. Resident #30 was unable to reach and initiate the pull-cord alarm. During a concurrent observation and interview on 06/16/2026 at 2:05 PM, NA #13 stated she thought Resident #30 was able to use the pull-cord alarm by using their thumb to trigger the alarm. NA #13 placed the pull-cord alarm without the string in the resident's hand, and requested for the resident attempt to trigger (initiate) the alarm, but the resident was unsuccessful. NA #13 stated the alarm had to be positioned a certain way before Resident #30 was able to get their thumb to trigger the alarm. During a telephone interview on 06/16/2026 at 9:55 PM, Licensed Practical Nurse #15 stated Resident #30 was not able to use a typical call light so staff placed an alarm in the resident's right hand, and she thought the resident was able to use the alarm. During a telephone interview on 06/16/2026 at 10:17 PM, NA #16 stated Resident #30 had a hand-held alarm, but he had not seen the resident trigger (initiate) the alarm. During an interview on 06/18/2026 at 2:22 PM, NA #17 stated if staff placed the blue part (the part without the string) of the alarm into Resident #30's hand that was wrong because the resident was not able to initiate the alarm. NA #17 stated she noticed that other staff placed the call light in Resident #30's hand wrong as they placed the alarm in the resident's hand instead of the string, but had not reported it to anyone. During an interview on 06/19/2026 at 9:49 AM, Director of Nursing #1 stated she expected the residents to have a call light that they could use to request assistance. During an interview on 06/19/2026 at 10:09 AM, the Administrator stated she expected the staff to properly place a resident's call light that was appropriate for the resident.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview, record review, and facility policy review, the facility failed to ensure as-needed antipsychotic medication was limited to 14 days for 1 (Resident #59) of 5 sampled residents reviewed for unnecessary medications.Findings included: A facility policy titled, Appendix 19: Medications Requiring Behavior & Side Effect Monitoring, updated 10/25/2021, specified, PRN [pro re nata, as needed] anxiolytics can have only an initial 14 day stop date. They can be continued for longer periods of time such as 30 [days], 60 [days], or 90 [days] days as long as the prescribing physician indicates that new stop date - they cannot be continued indefinitely. Per the Appendix 19: Medications Requiring Behavior & Side Effect Monitoring, Xanax was listed as an anxiolytic medication. An admission Record indicated the facility admitted Resident #59 on 01/04/2023. According to the admission Record, the resident had a medical history that included a diagnosis of anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/10/2026, revealed Resident #59 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident received antianxiety medication during the last seven days of the assessment period. Resident #59's Order Summary Report with active orders as of 06/16/2026, revealed an order dated 01/28/2026, for Xanax oral tablet 0.25 milligrams, give one tablet by mouth every 12 hours as needed for anxiety. Per the Order Summary Report, there was no end date specified for the Xanax medication. During an interview on 06/17/2026 at 12:38 PM, Nurse Practitioner (NP) #10 stated PRN medications required a 14-day stop (end) date. NP #10 reviewed Resident #59's medical record and confirmed the order for PRN Xanax was listed with no end date. NP #10 stated he expected PRN Xanax to have a stop date. During an interview on 06/17/2026 at 1:39 PM, the Medical Director (MD) stated PRN Xanax should have a stop (end) date of 14 days. The MD reviewed the order for PRN Xanax for Resident #59 and stated medication should have a stop end date as PRN Xanax should always have a stop date. During an interview on 06/17/2026 at 2:02 PM, Director of Nursing (DON) #1 stated psychotropic medication was supposed to have a stop (end) date. Per DON #1, PRN Xanax should have a stop date. DON #1 reviewed the order for Resident #59 and stated the PRN Xanax should have a stop date. DON #1 stated she expected PRN Xanax to have a stop date. During an interview on 06/17/2026 at 2:21 PM, the Administrator stated she was not involved in the process of PRN medications and stop (end) dates.

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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 interview, record review, document review, and facility policy review, the facility failed to ensure an allegation of abuse was timely reported to the state survey agency for 1 (Resident #72) of 1 sampled resident reviewed for abuse.Findings included: A facility policy titled, Reports to State and Federal Agencies, revised 02/02/2018, revealed, Timeline for Reporting. All reports to the Department shall be made by telephone or facsimile. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries on unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. An admission Record revealed the facility admitted Resident #72 on 11/06/2025. According to the admission Record, the resident had a medical history that included a diagnosis of malignant neoplasm of bone. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/2025, revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Resident #72's incident report prepared by Director of Nursing (DON) #1 and dated 12/18/2025 at 4:00 PM, indicated the resident reported to hospice staff that during the evening hours on 12/17/2025, a certified nursing assistant (CNA) was rough with them during the provision of incontinence care. Per the incident report, the hospice nurse reported the incident to staff, who then reported the incident to DON #1 and the Administrator. The incident report specified, Immediate Action Taken Description: Notified Administrator of allegation. The incident report indicated the physician and resident's family member were notified on 12/18/2025 at 4:23 PM. The Incident Report Form indicated the physician, resident's family, local law enforcement, and the nurse aide registry were notified on 12/18/2025 at 4:00 PM of an allegation of abuse/mistreatment. Per the Incident Report Form, Resident #72 alleged a CNA was rough with them during incontinence care. The Fax Transmission Report revealed the facility reported the allegation of abuse to the state survey agency on 12/18/2025 at 7:31 PM. During an interview on 06/18/2026 at 11:20 AM, DON #1 stated an allegation of abuse was supposed to be reported to the state survey agency within two hours. During an interview on 06/18/2026 at 10:32 AM, the former Administrator stated Resident #72 reported an allegation of abuse to a hospice nurse on 12/18/2025 and the hospice nurse informed her of the allegation on 12/18/2025 around lunchtime. During an interview on 06/18/2026 at 11:44 AM, the Administrator stated allegations of abuse should be reported to the state survey agency within two hours of staff becoming aware of the allegation. The Administrator stated the Incident Report Form indicated the resident's family, physician, local law enforcement, and nurse aide registry were notified of the allegation of abuse on 12/18/2025 at 4:00 PM and according to the Fax Transmission Report, the facility reported the allegation of abuse to the state survey agency on 12/18/2025 at 7:31 PM. The Administrator stated the initial report was not submitted to the state survey agency within two hours. Per the Administrator, she expected allegations of abuse to be reported within two hours.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and document review, the facility failed to educate the staff on the proper usage of a pull-cord alarm for 1 (Resident #30) of 1 sampled resident who required a specialized call light. Findings included: On 06/16/2026 at 10:30 AM, the Administrator stated the facility did not have a policy regarding accommodation of residents' needs. A document titled, AliMed Worry-Free Pull-Cord Alarm, #72140 Instructions for Use and Care, indicated, A tug on the cord in any direction will cause magnetic sensor to release and alarm will be triggered. An admission Record revealed the facility admitted Resident #30 on 10/19/2025. According to the admission Record, the resident had a medical history that included diagnoses of dementia and hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2026, revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had an impairment on both sides in their upper extremities. Resident #30's Care Plan Report included a focus area revised 12/12/2025, that indicated admission / discharge plan miscellaneous. Interventions specified the resident's call light alternative was a clip alarm (initiated 05/11/2026). During a concurrent observation and interview on 06/15/2026 at 10:40 AM, Nurse Aide (NA) #13 stated Resident #30 was not able to use a regular call light, but the resident had a hand-held alarm. NA #13 located the pull-cord alarm and pinned it to Resident #30's clothing on the left chest area. Resident #30 attempted to reach for the pull-cord alarm and was unsuccessful. NA #13 then placed the pull-cord alarm without the string in Resident #30's right hand and left the resident's room. During a concurrent observation and interview on 06/16/2026 at 2:05 PM, NA #13 stated she thought Resident #30 was able to use the pull-cord alarm by using their thumb to trigger the alarm. NA #13 placed the pull-cord alarm without the string in the resident's hand, and requested for the resident attempt to trigger (initiate) the alarm, but the resident was unsuccessful. NA #13 stated the alarm had to be positioned a certain way before Resident #30 was able to get their thumb to trigger the alarm. NA #13 stated she had not received any training on the call light that Resident #30 used and was only told by other staff how to use the call light. During an interview on 06/16/2026 at 12:15 PM, NA #14 stated he thought Resident #30 held the pull-cord alarm in their hand and used their thumb to trigger (initiate) the alarm. NA #14 stated he had not received any training for the specialized call light used by Resident #30. During a telephone interview on 06/16/2026 at 9:55 PM, Licensed Practical Nurse #15 stated she had not received any training on how to use the pull-cord alarm utilized by Resident #30. During a telephone interview on 06/16/2026 at 10:17 PM, NA #16 stated he had not received any training on how to use the pull-cord alarm utilized by Resident #30. During an interview on 06/19/2026 at 9:49 AM, Director of Nursing #1 stated the facility staff had not been trained on the pull-cord alarm, used by Resident #30, During an interview on 06/19/2026 at 10:09 AM, the Administrator stated the staff had not received any training on the pull-cord alarm used by Resident #30.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility policy review, the facility failed to ensure 1 (200 Hall medication cart) of 5 medication carts in the facility was kept locked when out of sight of the staff authorized to have access. Findings included: A facility policy titled, Medication Storage in the Facility, effective 01/2022, indicated, Policy Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is assessable only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy specified, Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. During a concurrent interview and medication administration observation on 06/16/2026 at 7:52 AM, Certified Medication Aide (CMA) #12, being trained by Licensed Practical Nurse (LPN) #8, was observed to leave the medication cart on the 200 Hall unlocked while she administered a resident's medications in the resident's room approximately 55 feet away from the medication cart. The top drawer of the medication cart consisted of over-the-counter medications such as aspirin, vitamins, stool softeners, glucometer strips, and lancets, and the second drawer consisted of bubble packs of residents' medications to include Eliquis, a blood thinner; metoprolol, an antihypertensive medication; methocarbamol, a muscle relaxant; and furosemide, a diuretic medication. At 7:58 AM, both CMA #12 and LPN #8 walked back to the medication cart and upon reaching the cart, LPN #8 locked the medication cart. At that time, they were both asked if they left the medication cart unlocked and they both replied, the medication cart was unlocked. The Pharmacy Consultant (PC) was observed standing approximately 2 feet away from the unlocked cart. CMA #12 stated she thought she locked the medication cart, and LPN #8 stated she did not notice the medication cart was unlocked until she returned to the medication cart. Both, CMA #12 and LPN #8, stated they had been trained to keep the medication cart locked when unattended. During an interview on 06/16/2026 at 8:04 AM, the PC stated there was not a problem with medication labeling but there was a problem with storage as she witnessed the unlocked medication cart. During an interview on 06/19/2026 at 1:30 PM, Director of Nursing #1 stated she expected the nurses and medication aides to keep the medication carts locked when the medication carts were out of their sight. During an interview on 06/19/2026 at 1:48 PM, the Administrator stated she expected the nurses and medication aides to keep the medication carts locked when the medication carts were out of their sight.