STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375155	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Skilled Nursing and Therapy	1921 Northeast 21st Street Oklahoma City, OK 73111

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure:a. a discharge assessment was completed and transmitted for 2 (#25 and #54): b. an entry record was completed and transmitted for 2 (#54 and #81) of 17 sampled residents reviewed for timely encoding and transmitting of resident assessments.The administrator identified 68 residents resided in the facility. Findings: 1. The RAI manual, dated 10/2025, showed discharge assessments were to be completed no later than 14 days after the discharge. The assessment then must be transmitted no later than 14 days after the completion of the assessment. An admission assessment, dated 12/02/25, showed Resident #25 was admitted to the facility on [DATE] with a BIMS score of 11 which indicated moderate cognitive impairment. A nurse's progress note, dated 12/11/25 at 12:02 p.m., showed Resident #25 refused to enter the facility after returning from dialysis. A nurse's progress note, dated 12/12/25 at 12:10 p.m., showed Resident #25 had left the faciity on [DATE] without a proper discharge or their medications. The last assessment completed and transmitted was the entry tracking record, dated 12/09/25. There was no discharge assessment indicating Resident #25 had left the faciity on [DATE]. On 05/20/26 at 9:47 a.m., MDS Coordinator #1 stated Resident #25's discharge assessment should have been completed but was not. MDS Coordinator #1 stated they kept a calendar on their desk to track required assessments. MDS #1 stated the discharge assessment must have been missed by MDS Coordinator #2. 2. The Center for Medicare and Medicaid Services, Long Term Care Facility Resident Instrument 3.0 User's Manual, dated 10/2025, showed admission assessments must be encoded within 13 days of a resident's entry and transmitted within 14 days after a facility completes a resident's care plan assessment. A nurse's progress note, dated 02/26/26, showed Resident #54 left the facility with EMSA for the ER. Resident #54 was readmitted to the facility on [DATE]. There was no discharge return anticipated or reentry admission assessments completed for this date. A nurse's progress note, dated 03/15/26, showed Resident #54 was hospitalized . Resident #54 was readmitted to the facility on [DATE]. There was no discharge return anticipated or reentry admission (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375155	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Skilled Nursing and Therapy	1921 Northeast 21st Street Oklahoma City, OK 73111

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments completed for this date. A nurse's progress note, dated 03/31/26, showed Resident #54 left the facility with EMSA to the ER. Resident #54 was readmitted to the facility on [DATE]. There was no discharge return anticipated or reentry admission assessments completed for this date. On 05/21/26 at 10:44 a.m., MDS Coordinator #2 stated Resident #54 was missing some MDS assessments, and they were behind and would get to them. MDS coordinator #2 stated the missing entry assessments should have been done. 3. A discharge return anticipated entry assessment, dated 04/13/26, showed Resident #81 was discharged from the facility and transferred to the hospital. A nurse's progress note, dated 04/17/26, showed Resident #81 returned from the hospital. There was no MDS entry assessment showing Resident #81 had returned to the facility. On 05/21/26 at 10:43 a.m., MDS Coordinator #2 stated they should have entered a record of entry upon Resident #81's return to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375155	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Skilled Nursing and Therapy	1921 Northeast 21st Street Oklahoma City, OK 73111

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to clearly distinguish the arbitration agreement from the admission agreement and ensure residents or their representatives were able to sign the admission agreement without consenting to the facilities arbitration agreement.The administrator identified 68 residents resided in the facility. The administrator and the admissions coordinator identified 68 residents/representatives had agreed to arbitration.Findings:An Introductory Note, located on page 2 of the admission packet, read in part, This admission Agreement, including the Dispute Resolution Provision\Agreement, (the Agreement} represents an Agreement between the Resident, the Resident Representative (if applicable, as defined and to the extent explained herein and) [NAME] Skilled Nursing and Therapy.Item number 2 of the Dispute Resolution Provision\Agreement, located on page 21 of the admission packet, read in part, By entering into this agreement, both parties explicitly waive any right to have any Resident/Facility dispute decided in a court of law or equity, whether by or before a jury or by the court itself, and instead accept the use of neutral, binding arbitration as the sole means of dispute resolution.Item number 14 of the Dispute Resolution Provision\Agreement, located on page 24 of the admission packet, read in part, The Resident understands that agreement to arbitration by the resident is not a condition of admission to, or a requirement to continue receiving care at, the Facility. In other words, the resident has the right to reject arbitration and still be admitted to, or continue receiving care at, the Facility.The most recent assessments conducted for Residents' #2, 4, 5,13, 22, 23, 24, and 42 all showed the Residents had a BIMS score of 15, indicating intact cognition.The most recent assessment conducted for Residents' #17, 43, 75, and 85 all showed the Residents had a BIMS score of 14 indicating intact cognition. On 05/19/26 at 10:05 a.m., a resident council meeting was conducted between the surveyor and attendees which included Residents #2, 4, 5, 7, 13, 17, 22, 24, 31, 40, 51, 59, and #75. On 05/19/26 at 10:35 a.m., the consensus of the attendees of the resident council meeting was no one knew what an arbitration agreement was and they were unaware if they had signed one.On 05/20/26 at 9:56 a.m., the admissions coordinator stated if a resident did not want to sign the arbitration agreement, then the signatures would be stopped, and they would need to print the packet so the resident would not have to sign the arbitration agreement. The admissions coordinator stated they ensured residents understood their right not to sign the arbitration agreement by reading a script that stated the residents did not have to sign the arbitration agreement and they also had 30 days to rescind by written documentation. On 05/20/26 at 11:53 a.m., Resident #85 stated they had been in the facility a little over a year. Resident #85 stated they did not know what an arbitration agreement was and did not know if they had signed one. Resident #85 stated they went over the admission paperwork fast and they do not remember what was included. On 05/20/26 at 12:00 p.m., Resident #43 stated they had been in the facility for about eight months. Resident #43 stated the facility did not go through their paperwork for admission. Resident #43 stated they did not know what an arbitration agreement was and did not sign it. On 05/20/26 12:03 p.m., Resident #17 had been in the facility for about four years. Resident #17 stated they did not know what an arbitration agreement was and they do not remember anything about it. On 05/20/26 at 12:06 p.m., Resident #23 stated they had been in the facility for about six or seven years. Resident #23 stated they signed a bunch of stuff way back then. Resident #23 stated they did not know what an arbitration agreement was. On 05/21/26 at 11:46 a.m., the administrator stated a script was read to the residents when discussing the admission packet. The administrator stated If the resident says they understand, then I believe them. The administrator stated the arbitration agreement did not void the residents' rights to go to court because I have had lawsuits.On 05/21/26 at 12:00 p.m., Corporate Nurse Consultant #1 and #2 both stated signing an arbitration agreement did not take away the resident's rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375155	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Skilled Nursing and Therapy	1921 Northeast 21st Street Oklahoma City, OK 73111

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure medications had a physician's order, were documented, and secured for 1 (#65) of 1 sampled resident observed for self-administration of medication.The administrator identified one resident self-administered medications in the facility. Findings:On 05/18/26 at 10:24 a.m., Resident #65 was observed sitting on their bed watching television with a bedside table full of supplements which included magnesium citrate 250 mg, black elderberry, Co Q-10 100 mg, Ashwagandha, and a fiber prebiotic.On 05/21/26 at 11:10 a.m., magnesium citrate 250 mg, black elderberry, Co Q-10 100 mg, Ashwagandha, and fiber prebiotic supplement medication bottles were observed on Resident #65's bedside table out in the open as before. Resident #65 was not observed in their room at this time, but their roommate was present.A review of Resident #65's active orders did not include those found on their bedside table or an order permitting the resident to self-administer medications.A facility policy titled Resident Self-Administration of Medications Guideline, dated June 2025, read in part, A written order from the physician is required to permit the resident to self-administer medications. The order should specify which medications may be self-administered. Self-administration of medications should be reflected on resident's care plan. Medications approved for self-administration must be stored safely and securely, either in resident's room (if safe to do so) or in a location accessible only to the resident and authorized staff.A medication self-administration assessment, dated 12/28/25, deemed Resident #65 safe to self-administer medications. The assessment did not list which medications were safe for the resident to self-administer.A quarterly MDS assessment, dated 03/31/26, showed Resident #65 had diagnoses which included pain due to internal orthopedic prosthetic device, history of falling, essential (primary) hypertension, and gastro-esophageal reflux disease without esophagitis. The assessment showed the resident had a BIMS score of 15, which indicated intact cognition.A care plan, dated 04/08/26, showed Resident #65 did not have a self-administration focus in place. On 05/18/26 at 10:24 a.m., Resident #65 stated they took their supplements to lose weight and maintain their health. They stated they did not get the chance to speak to their doctor about a weight loss regimen but were hoping to do so.On 05/21/26 at 11:14 a.m., RN #1, stated residents could not keep supplements in their room and all medication should be documented and kept in a medication cart. RN #1 stated if residents were taking medication that was undocumented, then the facility might not know what was going on if any negative health issues occurred. RN #1 stated they did not know Resident #65 had a bedside full of supplements and stated the resident was not allowed to have that. RN #1 stated CNAs were supposed to report to the nurses if they saw this kind of thing. RN #1 stated no residents have told them they were taking supplements to lose weight and all supplements a resident takes needs to have an order from their physician.On 05/21/26 at 1:50 p.m., the DON stated Resident #65 had purchased the medications today to take with them because they were getting discharged the next day and would not need an order or medication safety storage because they were getting discharged . The DON was informed Resident #65 was observed with the medications at their bedside since 05/18/26, to which the DON stated they did not know about this and the resident was known to go out and purchase supplements from a store near the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375155	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Skilled Nursing and Therapy	1921 Northeast 21st Street Oklahoma City, OK 73111

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interview, the facility failed to ensure an admission assessment was completed for 1 (#4) of 17 sampled residents reviewed for admission assessments. The administrator identified 68 residents resided in the facility. Findings: Centers for Medicare and Medicaid Services RAI Manual page 2-22, dated October 2025, read in part, The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. A discharge return anticipated entry assessment, dated 03/28/26, showed Resident #4 was discharged from the facility and transferred to the hospital. An MDS data entry assessment, dated 04/30/26, showed Resident #4 had returned to the facility. There was no comprehensive assessment for Resident #4's readmission to the facility. On 05/20/26 at 11:20 a.m., MDS Coordinator #1 stated Resident #4 should have had an admission assessment completed for readmission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375155	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Skilled Nursing and Therapy	1921 Northeast 21st Street Oklahoma City, OK 73111

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 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 nail care assistance for 1 (#20) of 4 sampled residents observed for ADLs.The administrator identified 68 residents resided in the facility. Findings:On 05/18/26 at 10:59 a.m., Resident #20 was observed lying in bed watching television. Resident #20's nails were observed to be long and had brown substance underneath. Resident #20 was observed trying to mumble a concern but could not be understood.On 05/21/26 at 11:33 a.m., Resident #20's nails were observed to be long and had brown substance underneath.A review of electronic health record from 2026 had no documentation Resident #20's family member had requested to come to the facility to provide nail trimming.Resident #20's undated medical record face sheet showed diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, facial weakness following cerebral infarction, and dysarthria following cerebral infarction.An admission assessment, dated 04/15/26, showed Resident #20 needed partial/moderate assistance in shower/bathing, and needed substantial/maximal assistance in personal hygiene. The assessment showed Resident #20 had a BIMS score of 8, which indicated moderately impaired cognition.A care plan, dated 4/28/26, showed Resident #20 had a communication problem due to a diagnoses of dysarthria following cerebral infarction and facial weakness following cerebral infarction. The care plan did not include an ADL intervention for nail care. On 05/21/26 at 11:34 a.m., RN #1 stated Resident #20's nails looked like they had been growing for a month long. RN #1 stated some residents refuse nail care but would have to check if Resident #20 did.Om 05/21/26 at 1:18 p.m., CNA #1 stated they provided nail care for Resident #20 almost every day and did this by washing the resident's hands and cleaning under their nails with a nail care tool. CNA #1 stated they did not clip Resident #20's nails because the resident's family member requested to cut them and has told CNA #1 this.On 05/21/26 at 1:22 p.m., CNA #1 stated Resident #20's nails did not look clean and might have had food under them because the resident had just eaten.On 05/21/26 at 1:50 p.m., the DON stated their expectations for care nail from the CNAs were to clean and trim the nails for non-diabetic residents. The DON stated that nail care would be considered important for a resident who struggled to carry out ADLs. The DON stated CNAs told nurses if a resident refused nail care, and then staff tried to provide care again later or contact the resident's family for support. The DON stated they did not know about the resident's family member requesting to cut the nails and this would have to be care planned and they would need to add it in.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375155	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Skilled Nursing and Therapy	1921 Northeast 21st Street Oklahoma City, OK 73111

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 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 observation, record review, and interview, the facility failed to ensure discontinued and expired medications were disposed of for 1 (#6) of 1 sampled resident whose medication was observed in the medication storage room refrigerator.The administrator identified one medication storage room in the facility. Findings:On 05/20/26 at 10:44 a.m., four syringes of Lorazepam Oral Concentrate (an anti-anxiety medication) 2MG/ML for Resident #6 were observed in the medication room. The Lorazepam Oral Concentrate had an expiration date of 05/05/26.A Storage of Medications policy, effective January 2022, read in part, All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining.A nurse's progress note, dated 02/24/26, showed Resident #6 received a new order for Lorazepam Oral Concentrate 2MG/ML 0.5 ml every four hours as needed. A physician's order, dated 02/25/26, showed Resident #6's Lorazepam Oral Concentrate was discontinued on 02/25/26.On 5/20/26 at 10:45 a.m., Certified Medication Aide #1 reviewed the expired Lorazepam Oral Concentrate and removed it from the refrigerator. They stated it should have been removed from the medication storage room when the medication was discontinued. On 05/20/26 at 3:05 p.m., the DON stated the Lorazepam Oral Concentrate should have been removed from the refrigerator in the medication storage room when it was discontinued, but no later than the same day it expired.