STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375206	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Nursing & Rehab	1103 West Cherokee Lindsay, OK 73052

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to ensure a resident's care plan was updated with interventions for safe storage of portable oxygen cylinders for 1 (#1) of 4 sampled residents reviewed for oxygen therapy. The administrator identified 11 residents used oxygen in the facility. Findings: On 04/14/26 at 9:20 a.m., Resident #1's room was observed to have 25 small cylinders of oxygen stored in their closet. The oxygen cylinders were observed standing up and tipped over on the floor of Resident #1's closet.On 04/14/26 at 1:30 p.m., the DON was asked to check the oxygen cylinders in Resident #1's closet to ensure they were empty. The DON was observed to check some of the oxygen cylinders. Two oxygen cylinders were observed to be full.A policy titled Care Plans, Comprehensive Person-Centered, dated 12/01/16, read in part, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.An annual assessment for Resident #1, dated 01/13/26, showed the resident's cognition was intact with a BIMS score of 15. The assessment showed Resident #1 was independent with activities of daily living, received oxygen therapy, and had chronic obstructive pulmonary disease.A care plan for Resident #1, dated 02/03/26, showed the resident had oxygen therapy. The care plan showed to provide Resident #1 with a portable oxygen apparatus. The care plan did not show interventions related to Resident #1's unsafe storage of portable oxygen cylinders brought into the facility.A physician's order for Resident #1, dated 02/25/26, showed administer oxygen at two liters per minute via nasal cannula as needed for a history of respiratory failure.On 04/14/26 at 9:20 a.m., Resident #1 stated the facility would not supply the small portable oxygen cylinders they used in an over-the-shoulder carrier bag. Resident #1 stated they brought the oxygen cylinders to the facility from a family member's home.On 04/14/26 at 10:36 a.m., CNA #1 stated no residents stored portable oxygen cylinders unsecured in their rooms or closets. On 04/14/26 at 1:20 p.m., the DON stated portable oxygen cylinders had been removed from Resident #1's room several times for safety. The DON stated they were not aware of what interventions had been put in place to prevent Resident #1 from storing oxygen cylinders in their closet. The DON stated interventions to ensure the resident was not storing oxygen cylinders unsecured should have been included on the care plan.On 04/14/26 at 1:47 p.m., the administrator stated they were unaware Resident #1 had oxygen cylinders stored in their closet. The administrator stated the oxygen cylinders had been removed and the care plan would be updated.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375206	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Nursing & Rehab	1103 West Cherokee Lindsay, OK 73052

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure portable oxygen cylinders were not stored unsecured in a resident's closet for 1 (#1) of 4 sampled residents reviewed for oxygen storage which had the potential to cause a severe fire hazard. The administrator identified 11 residents in the facility used oxygen. Findings:An undated Oxygen Storage and Safety policy, provided by the administrator on 04/14/26, showed full cylinders must be stored in a designated, well-ventilated area. The policy showed empty cylinders must be stored separately and labeled Empty. The policy showed oxygen in resident rooms must be secured to prevent tipping. The policy showed routine checks will be conducted to ensure proper storage and safety.An annual assessment for Resident #1, dated 01/13/26, showed the resident's cognition was intact with a BIMS score of 15. The assessment showed Resident #1 was independent with activities of daily living. The assessment showed Resident #1 received oxygen therapy and had diagnoses of chronic obstructive pulmonary disease and respiratory failure.A care plan for Resident #1, dated 02/03/26, showed the resident had oxygen therapy. The care plan intervention for Resident #1 showed a portable oxygen apparatus was to be provided. The care plan did not show interventions related to Resident #1's unsafe storage of portable oxygen cylinders brought into the facility.A physician's order for Resident #1, dated 02/25/26, showed administer oxygen at two liters per minute via nasal cannula as needed for a history of respiratory failure.Resident #1's medical record had no documentation the facility checked the resident's room for safe oxygen storage.On 04/14/26 at 9:20 a.m., Resident #1's room was observed to have 25 small cylinders of oxygen for an over-the-shoulder carrier bag stored in their closet. The oxygen cylinders were observed unsecured, standing up, and tipped over on the floor of Resident #1's closet.On 04/14/26 at 1:30 p.m., the DON was observed to check the oxygen cylinders in Resident #1's closet to ensure they were empty. The DON was observed to check three of the portable oxygen cylinders in Resident #1's closet, and two were found to be full.On 04/14/26 at 9:20 a.m., Resident #1 stated the facility would not supply the small portable oxygen cylinders they used in an over-the-shoulder carrier bag. Resident #1 stated they brought the oxygen cylinders to the facility from a family member's home. Resident #1 stated there were only empty cylinders in their closet and they had not stored full bottles in the closet.On 04/14/26 at 10:36 a.m., CNA #1 stated oxygen cylinders were to be stored in a locked room on the back hall designated for oxygen. CNA #1 stated no oxygen cylinders should be stored in residents' rooms.On 04/14/26 at 10:57 a.m., housekeeper #1 stated they had seen oxygen cylinders stored in Resident #1's closet when hanging up the resident's clothes. Housekeeper #1 stated they were not aware the oxygen cylinders were not allowed to be there.On 04/14/26 at 1:20 p.m., the DON stated oxygen cylinders were to be stored secured in a rack in a locked closet on the back hall of the facility. The DON stated they were not aware Resident #1 currently had any oxygen cylinders stored in their closet. The DON stated they had removed oxygen cylinders stored in Resident #1's room several times for safety. The DON stated they were not aware of what interventions had been put in place to prevent Resident #1 from storing oxygen cylinders in their closet.On 04/14/26 at 1:47 p.m., the administrator stated they were unaware Resident #1 had oxygen cylinders stored in their closet. The administrator stated the oxygen cylinders would be removed and Resident #1 and their family would be educated about the safety concern and policy for oxygen storage.