STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375222	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24th Place	600 24th Avenue Southwest Norman, OK 73069

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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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 0693 Level of Harm - Actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure physician's orders were followed for enteral feeding for 1 (#1) of 1 resident sampled for enteral feeding.The administrator identified 72 residents resided in the facility. Findings:On 12/01/25 at 10:30 a.m., Resident #1 was observed resting in bed with their eyes open.A facility policy titled Enteral Tube Feeding via Syringe (Bolus), dated November 2018, read in part, Verify that there is a physician's order for this procedure. Report complications promptly to the supervisor and the Attending Physician.An undated medical diagnoses list showed Resident #1 had diagnoses which included esophagitis, dysphagia, and traumatic hemorrhage of cerebrum.An untitled document showed RN #1 completed their training on tube feeding on 07/10/25.Resident #1's treatment administration record, dated 10/01/25 to 10/31/25, showed Resident #1 had an order for Osomolite 1.5 cal oral liquid (nutritional supplement), give 237 ml via peg tube every four hours. RN #1 initialed the 8:00 a.m. dose as being provided as ordered.A physician's order, dated 10/10/25, showed Osmolite (enteral nutrition) 1.5 Cal oral liquid, give 237 ml via peg tube every four hours for nutrient, flush peg tube with 60 ml of water before and after feeding.A nurse's note, dated 10/13/25, read in part, This patient was fed this morning by peg tube as requested, at 10:00 a.m., and after about an hour the patient started coughing continually and throwing up, they aspirated on their food. After managing the situation for a while (raise the HOB, ensure patient is calm) this nurse [RN #1] texted the doctor at about midday and reported what happened, the Dr. advised the nurse [RN #1] to hold the midday feeding and monitor the patient. Dr. was notified at 11:48 a.m. that the resident was given to much formula. At 1:34 p.m., Dr. [name withheld] ordered the resident to be sent out to the ER for possible fluid overload and aspiration.A written statement, dated 10/13/25, showed LPN #1 was notified by a CNA, Resident #1 was vomiting. LPN #1 had notified RN #1 of the resident's condition and then asked RN #1 how much they fed Resident #1 through their peg tube. RN #1 reported two bottles, LPN #1 told RN #1 the physician's order showed one bottle each feeding.A nurse's note, dated 10/13/25 at 5:47 p.m., showed Resident #1 returned to the facility with no new orders.A care plan, dated 10/13/25, showed Resident #1 had a nutritional problem related to dysphagia. The goal showed Resident #1 would have clear lungs and no signs and symptoms of aspiration. A care plan intervention showed Resident #1 was sent to the emergency room for possible fluid overload aspiration.A typed and signed statement by the DON, dated 10/13/25, read in part, I asked the residents nurse [RN #1] how much Osmolite [they] administered via PEG tube, to which [they] responded, 'two containers.' I asked the nurse if [they] knew that was double, to which [they] replied 'Yes'.An entry on Resident #1's treatment administration record, dated 10/14/25, read in part, One time chest x-ray d/t wet cough, and for precautions as resident was sent out yesterday to r/o overload aspiration pneumonia.A mobile x-ray report, dated 10/14/25, showed Resident #1 had left basilar pneumonia.A physician's order, dated 10/15/25, showed Cefdinir (an antibiotic) 300 mg via peg tube two times a day for seven days for aspirational pneumonia.An admission assessment, dated 10/17/25, showed Resident #1's cognition was intact with a brief interview for mental status of 14. The assessment showed Resident #1 had a peg tube being utilized for nutrition.On 12/01/25 at 10:30 a.m., Resident #1 stated the staff took good care of them. Resident #1 stated they did not have feedings through their peg tube anymore.On 12/01/25 at 2:06 p.m., the DON stated RN #1 did not follow the physician's order and fed Resident #1 two cans of formula instead of one.

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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 0726 Level of Harm - 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 record review and interview, the facility failed to ensure an RN was competent and possessed the necessary skills to provide care for 1 (#1) of 1 resident sampled for peg tubes.The DON identified one resident with a peg tube. Findings:A facility policy titled Enteral Tube Feeding via Syringe (Bolus), dated November 2018, read in part, Verify that there is a physician's order for this procedure.An undated medical diagnoses list showed Resident #1 had diagnoses which included esophagitis, dysphagia, and traumatic hemorrhage of cerebrum.An untitled document showed RN #1 completed their training on tube feeding on 07/10/25.Resident #1's treatment administration record, dated 10/01/25 to 10/31/25, showed Resident #1 had an order for Osomolite 1.5 cal oral liquid (nutritional supplement), give 237 ml via peg tube every four hours. RN #1 initialed the 8:00 a.m. dose as being provided as ordered.A physician's order, dated 10/10/25, showed Osmolite (enteral nutrition) 1.5 Cal oral liquid, give 237 ml via peg tube every four hours for nutrient, flush peg tube with 60 ml of water before and after feeding.A nurse's note, dated 10/13/25, read in part, This patient was fed this morning by peg tube as requested, at 10:00 a.m., and after about an hour the patient started coughing continually and throwing up, they aspirated on their food. After managing the situation for a while (raise the HOB, ensure patient is calm) this nurse [RN #1] texted the doctor at about midday and reported what happened, the Dr. advised the nurse [RN #1] to hold the midday feeding and monitor the patient. Dr. was notified at 11:48 a.m. that the Resident was given to much formula. At 1:34 p.m., Dr. [name withheld] ordered the Resident to be sent out to the ER for possible fluid overload and aspiration.A written statement, dated 10/13/25, showed LPN #1 was notified by a CNA Resident #1 was vomiting. LPN #1 had notified RN #1 of the resident's condition and then asked RN #1 how much they fed Resident #1 through their peg tube. RN #1 stated two bottles, LPN #1 told RN #1 the physician's order showed one bottle each feeding.An entry on Resident #1 treatment administration record, dated 10/14/25, read in part, One time chest x-ray d/t wet cough, and for precautions as resident was sent out yesterday to r/o overload aspiration pneumonia.A mobile x-ray report, dated 10/14/25, showed Resident #1 had left basilar pneumonia.On 12/01/25 at 2:06 p.m., the DON stated RN #1 did not follow the physician's order and fed Resident #1 two cans of formula instead of one.