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	10/02/2025

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

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], an IJ situation was determined to exist related to the facility's failure to provide oxygen as ordered by the physician. Resident #77 was found unresponsive and without oxygen on [DATE]. The resident expired in the facility. Resident #77 had a physician order for continuous oxygen at 2 liters per minute per nasal cannula. On [DATE] at 3:01 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 3:12 p.m., the administrator was notified of the IJ and provided the IJ template. On [DATE] at 12:33 p.m., an amended plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Immediate Plan Of RemovalFacility revied [sic] all patients with oxygen orders on 9-29-2025 by 5:00 p.m. to ensure appropriate physician orders are in place, pulse ox, oxygen saturation, and liters ordered per patients is monitored Q shift per policy, and documentation is completed in each resident Emar Q shift. All patients with prn oxygen will have pulse ox checked every shift and prn.All available Nursing staff will be in-serviced on 9-30-2025 by 6:00 p.m. over all patients that require oxygen. All unavailable employees will be removed from schedule and in-service completed on their return before starting a shift. All agency staff will be in-serviced when entering facility for a shift and in-service sent to agency management to complete with their employees that they may send to our facility.All available nursing staff will be in-serviced by [name withheld], RN and [name withheld], RN on 9-30-2025 by 6p.m. over Facility Oxygen administration policy ensuring that all residents with oxygen orders, have pulse ox monitored, oxygen saturation, and liters of oxygen per patient orders monitored Q shift per policy, and documentation is completed in each residents Emar Q shift. All residents with prn oxygen orders pulse ox will be monitored every shift and prn. All unavailable employees will be removed from schedule and in-service completed on their return before starting a shift. All agency staff will be in-serviced when entering facility before beginning a shift.All oxygen concentrators for patients with continuous and prn oxygen were audited on 9-29-2025 by 6:00 p.m. to ensure all are in working order and all hoses and machines are connected correctly.All oxygen concentrators for patients with continuous oxygen will be monitored per shift to ensure all are in working order and all hoses and machines are connected correctly. Monitoring check off sheets will be reviewed at stand up for any concerns. All patients with prn oxygen will have their concentrators checked weekly to ensure properly functioning and oxygen tubing is readily available.All available nursing staff will be in-serviced by [name withheld], RN and [name withheld], RN 9-30-2025 by 6 p.m. over the designated area for the facility crash cart in order to ensure they are able to locate it in a timely manner in an emergency situation. All unavailable employees will be removed from schedule and in-service completed on their return before starting a shift. All agency staff will be in-serviced when entering facility for a shift and in-service sent to agency management to complete with their employees that they may send to our facility.The IJ was lifted effective [DATE] at 6:00 p.m., after all components of the plan of removal were verified as corrected. Policy and procedure for oxygen was reviewed. Orders for oxygen were verified. Audits were verified. In-services were verified and staff communicated they had received in-service in regard to abuse. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on observation, record review, and interview, the (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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility failed ensure:a. a resident received oxygen as ordered for 1 (#77); andb. a resident had an order for the use of oxygen for 1 (#31) of 2 sampled residents reviewed for respiratory care.The corporate nurse consultant identified two residents who received continuous oxygen resided in the facility. Findings: 1.An undated diagnoses report showed Resident #77 had diagnoses which included acute respiratory distress and chronic obstructive pulmonary obstruction. A care plan intervention, dated [DATE], read in part, Give oxygen therapy as ordered by the physician. A physician's order, dated [DATE], showed Resident #77 was to receive oxygen at 2 liters per nasal cannula continuous every shift. Resident #77's admission assessment, dated [DATE], showed Resident #77 required substantial/maximum assistance with repositioning and transfers and required the use of oxygen. A health status note, dated [DATE] at 3:30 p.m., read in part, Called to room by CNA, resident's Oxygen is unhooked and resident is cold, and blue, with no carotid pulse or respirations. Began Chest compressions x [times] 12 minutes until [ambulance service] arrived and took over. A health status note, dated [DATE] at 3:59 p.m., read in part, [ambulance service] and Paramedics called code. Resident is deceased . On [DATE] at 11:57 a.m., CNA #3 stated, As soon as I saw [Resident #77], was pale, [their] eyes were open and dried out. The oxygen hose was unplugged from the machine. [Resident #77] was dead as soon as I saw [them]. On [DATE] at 12:01 p.m., CNA #3 stated there was no in-service after Resident #77 was found unresponsive and pronounced deceased at the facility by the ambulance service. On [DATE] at 1:06 p.m., LPN #3 stated Resident #77 was found unresponsive. On [DATE] at 1:10 p.m., LPN #3 stated they initiated cardiopulmonary resuscitation and the ambulance service took over when they arrived. They stated it was a lengthy code and the ambulance service pronounced the resident deceased at the facility. On [DATE] at 1:23 p.m., corporate nurse consultant #1 stated the policy for monitoring residents with oxygen was to chart once a shift that they were on oxygen and chart their oxygen saturation. They stated staff were to check the tubing placement and ensure appropriate liters at least every shift. 2. On [DATE] at 8:57 a.m., Resident #31 was observed on 3 liters of oxygen via nasal cannula. An Oxygen Administration policy, revised 10/2010, read in part, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. A care plan, revised [DATE], showed Resident #31 had diagnoses which included acute respiratory failure with hypoxia and hypoxemia. The care plan showed to provide oxygen as ordered. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #31's annual resident assessment, dated [DATE], showed the resident's cognition was intact with a BIMS of 15. There was no documentation Resident #31 had an order for the use of oxygen. On [DATE] at 8:57 a.m., Resident #31 stated they were on oxygen for more than three months. They stated they were on 3 liters of oxygen. On [DATE] at 9:18 a.m., LPN #2 stated a physician's order was needed for oxygen administration. On [DATE] at 9:19 a.m., LPN #2 stated Resident #31 was on oxygen. On [DATE] at 9:22 a.m., LPN #2 stated Resident #31 did not have a physician's order for the use of oxygen. On [DATE] at 9:23 a.m., LPN #2 stated the resident was on three liters of oxygen. On [DATE] at 3:07 p.m., corporate nurse consultant #1 stated residents needed a physician's order for oxygen use.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure fall interventions were initiated to prevent reoccurring falls for 1 (#10) of 2 sampled residents reviewed for falls.The administrator identified 74 residents resided in the facility. Findings: A review of March 2025 incidents showed Resident #10 had a non-injury fall on 03/07/25 and 03/17/25.Resident #10's fall risk assessment, dated 03/17/25, showed the resident had moderate risk for falls with a score of 9.An incident report, dated 03/19/25 at 9:00 p.m., read in part, Notified by staff that resident had a fall. Nursing assessment completed and observed with 5cmx5cm scalp hematoma. Neurological checks initiated and resident was assisted to bed. Resident states [gender withheld] was trying to close the curtain and lost [gender withheld] balance.Resident #10's fall risk assessment, dated 03/19/25, showed the resident had moderate risk for falls with a score of 13.There were no documented interventions to prevent falls or injuries related to the fall on 03/19/25.Resident #10's annual resident assessment, dated 03/20/25, showed the resident's cognition was intact with a BIMS of 15. The assessment showed the resident was independent with bed mobility, transfer, and walking at least 150 feet. The assessment showed the resident used a walker. The assessment showed the resident had two or more non major injury falls.An incident report, dated 04/04/25 at 11:10 p.m., read in part, Residents roommate yelled to notify nursing staff that [Resident #10] was in the floor. Upon entering the room Resident is witnessed sitting on floor beside roommates bed and electric W/C [wheelchair]. Resident complains of Left Hip and leg pain. Left leg is visible shortened by 2-3 inches and Left knee is turned inward to the right. [Resident #10] reports feeling like [gender withheld] hip did when [gender withheld] had surgery on it two years ago. [Resident #10] states I was trying to get back to my walker and I fell. The report showed the resident's walker was in their bathroom.A nursing note, dated 04/05/25 at 12:05 a.m., showed Resident #10 was sent to the emergency room.A hospital operative report, dated 04/05/25, showed a preoperative diagnosis of left distal femur supracondylar fracture.Resident #10's admission resident assessment, dated 04/18/25, showed the resident's cognition was intact with a BIMS of 15. The assessment showed the resident required partial to moderate assistance with bed mobility and transfer.An incident report, dated 04/19/25 at 6:15 p.m., showed Resident #10 had a non-injury fall. The report showed the resident slid off their wheelchair.On 09/23/25 at 12:51 p.m., Resident #10 stated they tripped over their roommate's wheelchair, fell and broke their left hip about four months ago.On 10/01/25 at 10:03 a.m., CNA #2 stated Resident #10 could transfer themselves into their wheelchair and used their walker during therapy.On 10/01/25 at 10:04 a.m., CNA #2 stated Resident #10's fall interventions were to encourage the resident to use the call light for assistance and wheelchair in reach.On 10/01/25 at 10:09 a.m., Resident #10 stated they had a fall while trying to adjust their privacy curtain because the roommate's television images reflected in theirs and closing the curtain helped.On 10/01/25 at 10:25 a.m., LPN #1 stated nurses initiated fall interventions after each fall. They stated they could discuss the fall in morning meeting and come up with fall interventions if unable to come up with interventions on their own.On 10/01/25 at 10:31 a.m., LPN #1 stated Resident #10 had multiple falls in the facility.On 10/01/25 at 10:36 a.m., LPN #1 stated the 03/19/25 fall report showed Resident #10 fell while trying to close their curtain. They stated it could either be the window curtain or the privacy curtain. They stated no interventions were documented on the resident's report or electronic health record to prevent future falls.On 10/01/25 at 10:42 a.m., LPN #1 stated the report should have specified what curtain and the interventions could have been to educate the staff on closing the resident's curtain, educate the resident on calling for assistance, and the use of call light.On 10/01/25 at 11:10 a.m., the chief nursing officer stated if a resident fell, staff were to do an incident report, implement immediate interventions, notify family, physician, administrator, and director of nursing. They stated they did a track and trending and if the resident had two or more falls in a month, they would complete a Five (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Why to find the root cause of the falls. They stated the nurses would implement interventions to prevent reoccurring falls. On 10/01/25 at 11:13 a.m., the chief nursing officer stated they could not locate any interventions related to the fall on 03/19/25.On 10/01/25 at 11:35 a.m., the chief nursing officer stated they could not locate documentation a Five Why was completed after the fall on 03/17/25 and on 04/19/25.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. Based on observation and interview, the facility failed to ensure contact information for filing a complaint with the State agency was available to the residents.The administrator identified 74 residents resided in the facility. Findings:On 09/26/25 at 4:08 p.m., the administrator and surveyor observed the information board. On 09/26/25 at 2:38 p.m., the resident council group stated the contact information for filing a complaint with the State agency was covered and not visible. They stated they wanted to contact the State agency a month ago, but could not. On 09/26/25 at 4:06 p.m., the administrator stated the information for filing a complaint with the State agency was posted at the information board by the facility entrance. On 09/26/25 at 4:08 p.m., the administrator stated the contact information on the form was not visible to residents.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure the most recent state survey results were readily accessible to residents, family members, and legal representatives of the residents.The administrator identified 74 residents resided in the facility. Findings: On 09/26/25 at 1:39 p.m., the information board observed at the facility entrance showed the current survey and past three years of state survey were available at the screening desk.The surveyor was unable to locate the past survey results at the screening desk.On 09/26/25 at 2:34 p.m., the resident council group stated the past survey results were located at the nurses' station.On 09/26/25 at 4:13 p.m., the administrator provided the past survey results binder from inside the nurses station. They stated residents were not allowed to enter the nurses station. The administrator stated the results should be on the nurses station counter for resident access.On 09/26/25 at 4:23 p.m., the administrator stated the binder did not contain results of the 2024 annual recertification survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interview, the facility failed to ensure residents and their representatives were invited to care plan meetings for 2 (#4 and #31) of 18 sampled residents whose care plans were reviewed.The administrator identified 74 residents resided in the facility. Findings:A Care Plans, Comprehensive Person-Centered policy, revised 03/2022, read in part, The resident is informed of his or her right to participate in his or her treatment, and provided advanced notice of care planning conferences .If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.1. On 09/26/25 at 3:24 p.m., the resident council group stated the facility did not invite residents or their representatives to care plan meetings.2. Resident #31's annual resident assessment, dated 08/28/25, showed the resident's cognition was intact with a BIMS of 15.A review of Resident #31's care plan from January 2025 to October 2025 showed the resident had three quarters of care plan review. There was no documentation the resident or their representatives were invited to care plan meetings for the three quarters. A care plan, revised 08/28/25, showed Resident #31 had diagnoses which included acute respiratory failure with hypoxia and hypoxemia.On 10/01/25 at 3:01 p.m., resident representative #1 stated they had not been invited, but representative #2 may have been invited to care plan meetings.On 10/01/25 at 3:06 p.m., resident representative #2 stated they had not been invited to care plan meetings and they had not attended any care plan meetings for Resident #31.On 10/01/25 at 3:11 p.m., Resident Representative #3 stated they had not been invited to care plan meetings and they had not attended any care plan meetings for Resident #31.3. Resident #4's quarterly resident assessment, dated 09/11/25, showed the resident's cognition was intact with a BIMS of 15.A care plan, revised 09/17/25, showed Resident #4 had diagnoses which included right eye blindness, left eye blindness, and end stage renal disease.A review of Resident #4's care plan from January 2025 to October 2025 showed the resident had three quarters of care plan review. There was no documentation the resident or representatives were invited to care plan meetings for the three quarters.On 09/30/25 at 8:35 p.m., MDS coordinator #1 stated they could not locate documentation that Resident #4 and Resident #31 or their representatives were invited to care plan meetings. They stated care plan meetings were completed quarterly.On 10/01/25 at 3:35 p.m., the social services director stated they sent out care plan meetings invite via mail to the resident's families. They stated they notify residents prior to the meeting and on the day of the care plan meeting. They stated the MDS coordinators could send them out but they rarely retain MDS coordinators so they send the invites out.On 10/01/25 at 3:39 p.m., the social services director stated they did not keep a copy of the invites they sent out to resident families.On 10/02/25 at 1:05 p.m., Resident #4 stated they were not invited to any care plan meeting. They stated they never attended a care plan meeting at the facility.

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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 record review and interview, the facility failed to ensure insulin was administered per physician's orders for 1 (#6) of 5 sampled residents reviewed for unnecessary medications.The administrator identified 74 residents resided in the facility.Findings: An Insulin Administration policy, revised 2014, read in part, To provide guidelines for the safe administration of insulin to residents with diabetes.Document the resident's blood glucose before intervention.Note blood sugar after each administration An undated Diagnosis Report, showed Resident #6 had diagnosis which included type II diabetes mellitus.Physician orders, dated 01/23/25, showed to administer insulin glargine 69 units one time a day and insulin glargine 72 units one time a day.An August 2025 MAR showed missed doses for:a. insulin glargine 69 units on 08/09/25, 08/10/25, and 08/13/25 andb. insulin glargine 72 units on 08/19/25.A September 2025 MAR showed missed doses for: a. insulin glargine 69 units on 09/02/25 and 09/05/25 andb. insulin glargine 72 units on 09/20/25.On 10/02/25 at 11:41 a.m., LPN #4 stated if there was a blank on the medication administration record it meant it was not given, not done. They stated Resident #6 did not receive insulin on the days above.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview, the facility failed to follow the menu for mechanical soft portion size for 1 of 1 meal service observed.A Diet Type Report, dated 09/29/25, showed six residents received a mechanical soft diet. Findings:On 09/29/25 at 11:54 a.m., a #16 scoop (equivalent to 2 ounces) was observed on the grounded mechanical soft chicken pan.On 09/29/25 at 12:04 p.m., one #16 scoop of grounded chicken was put on a resident's plate.On 09/29/25 at 12:06 p.m., one #16 scoop of grounded chicken was put on a resident's plate.The PREPARATION OF FOODS policy, dated 07/2020, read in part, measured utensils are used to serve proportions as described on the menu.A 2025 Week 3 Day 16 menu showed to use a #8 scoop (equivalent to 4 ounces) to serve the grounded crunchy chicken ranch.On 09/26/25 at 3:26 p.m., a resident council group stated the meal portion sizes were either too large or too small.On 09/29/25 at 12:16 p.m., cook #1 stated they reviewed the serving sizes in the extended menu book prior to meal services.On 09/29/25 at 12:18 p.m., cook #1 stated they had used the wrong serving size for the mechanical soft chicken. They stated they should have used the #8 scoop.On 09/29/25 at 12:20 p.m., the dietary manager stated they followed portion sizes to prevent weight loss and ensure residents were full.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure EBP and appropriate use of gloves was followed during catheter and perineal care for 1 (#7) of 1 sampled resident reviewed for urinary catheter use.The administrator identified 74 residents resided in the facility. Findings: On 10/01/25 at 3:51 p.m., EBP sign was observed by Resident #7's door and had instructions to wear a gown and gloves. Personal protective equipment supplies were in a storage drawer by the door. The supplies included gowns. On 10/01/25 at 3:53 p.m., CNA #1 was observed to don gloves, told the Resident #7 they would be performing catheter care, and adjusted the resident's bed.On 10/01/25 at 3:55 p.m., CNA #1 was observed to don new gloves and clean Resident #7's catheter. CNA #1 proceeded to clean the resident's groin.On 10/01/25 at 4:01 p.m., CNA #1 was observed to wash their hands, don new gloves, and retrieve a new brief and pad. CNA #1 rolled Resident #7 to their left side.On 10/01/25 at 4:04 p.m., CNA #1 was observed to clean Resident #7's anal area. There was a fecal smear on the brief and anal area.On 10/01/25 at 4:05 p.m., with the same gloves, CNA #1 was observed to put the new brief on Resident #7 and the pad under the resident. They discarded the dirty brief and pad in a plastic bag. CNA #1 adjusted the resident in bed and put the resident's shorts back on.On 10/01/25 at 4:08 p.m., with the same gloves, CNA #1 was observed to empty Resident #7's catheter bag. They proceeded to wash their hands.On 10/01/25 at 4:12 p.m., CNA #1 was observed to take the trash out.CNA #1 did not have a gown on during Resident #7's care. An undated order summary for Resident #7 showed the resident had diagnoses which included other specified disorders of bladder, benign prostatic hyperplasia without lower urinary tract symptoms, and cerebral palsy.A physician's order for Resident #7, dated 08/09/23, showed catheter care every shift and as needed. The order showed to ensure the catheter bag had a privacy bag on at all times.On 10/01/25 at 4:15 p.m., CNA #1 stated the resident was on enhanced barrier precautions. They stated EBP meant to use gloves and change them every time you touched dirty.On 10/01/25 at 4:17 p.m., CNA #1 stated a gown was not needed for EBP and they did not have a gown on during the care that was provided for Resident #7.On 10/01/25 at 4:22 p.m., CNA #1 stated they thought they changed their gloves after cleaning the fecal smear.On 10/01/25 at 4:23 p.m., CNA #1 observed the EBP sign posted and stated they should have worn a gown during the resident's care.On 10/02/25 at 1:41 p.m., corporate nurse consultant #1 stated gowns and gloves were to be used for catheter care due to EBP. They stated gloves were to be changed when going from dirty to clean.