

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Colonial Park Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 600 West Frontage Road Okemah, OK 74859	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to develop a grievance policy, appoint a grievance official, and maintain documentation of the results of all grievances. These deficient practices had the potential to affect all 68 residents who currently resided in the facility. Findings included: A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2026, revealed the facility admitted Resident #21 on 06/22/2025. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. An annual MDS, with an ARD of 05/10/2026, revealed the facility admitted Resident #36 on 04/19/2019. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. During the Resident Council meeting on 07/14/2026 at 1:31 PM, with four residents in attendance, Resident #21 and Resident #36 stated they did not know what a grievance was nor how to file a grievance. During an interview on 07/14/2026 at 2:35 PM, the Business Office Manager stated the facility did not have a grievance policy. During an interview on 07/15/2026 at 3:00 PM, the Social Services Director (SSD) stated if a resident had a concern (grievance), she would notify the appropriate department and once a resolution was reached, she would inform the residents during their Resident Council meeting. The SSD stated there was no documentation of how a grievance was resolved or the resident's response to the resolution. During an interview on 07/15/2026 at 3:10 PM, the Administrator stated the facility did not have a grievance policy. During an interview on 07/16/2026 at 1:12 PM, the Director of Nursing (DON) stated he expected that if a resident had a concern (grievance), staff would resolve the concern within a reasonable amount of time and document what was done to resolve the resident's concern. The DON stated he was unaware if there was a grievance log or form. According to the DON, outside of the Resident Council, a resident's grievance was followed up on informally. During an interview on 07/15/2026 at 3:10 PM, the Administrator stated when a resident had a concern (grievance) they brought their concern to either a charge nurse, Resident Council, or the SSD. The Administrator acknowledged there was no way a resident could file a grievance anonymously. The Administrator stated the resident's concern, follow-up, resolution, resident notification and response to a concern was not documented. The Administrator acknowledged the facility did not have a grievance official. During a follow-up interview on 07/16/2026 at 1:41 PM, the Administrator stated she expected the grievance process to allow residents to file grievances and anonymously if they chose to do so and for the staff to communicate the resolution to the resident and document the response.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, facility policy review, and review of Occupational Safety and Health Administration (OSHA) guidance, the facility failed to ensure all staff were fit-tested for N95 respirator masks (masks used to protect residents and staff from the transfer of microorganisms that can cause infectious disease) prior to initial use and at least annually thereafter. This deficient practice had the potential to affect all 68 residents who resided in the facility. In addition, the facility failed to ensure a urinary catheter bag was not directly on the floor for 1 (Resident #64) of 1 sampled resident reviewed for catheter use. Findings included: 1. A facility policy titled, Staff Fit Testing for N95 Respirator Policy, implemented 03/05/2025, revealed, OSHA requires all healthcare facilities utilizing N95 respirators to provide Fit Testing to all staff on an at-hire and annual basis. An OSHA document titled, Part Number:1910, Part Number Title: Occupational Safety and Health Standards, Subpart: 1910 Subpart I, Subpart Title: Personal Protective Equipment, Standard Number: 1910.134, Title: Respiratory protection, specified, 1910.134(f)(2) The employer shall ensure that an employee using a tight-fitting facepiece respirator is fit tested prior to initial use of the respirator, whenever a different respirator facepiece (size, style, model or make) is used, and at least annually thereafter. During an interview on 07/16/2026 at 4:51 PM, Licensed Practical Nurse (LPN) #11 stated she had been employed at the facility since 2017 and could not recall the last time she was fit tested for N95 use. LPN #11 stated they had not been tested in the last year or two. During an interview on 07/16/2026 at 4:54 PM, LPN #6 stated he was last tested for N95 use around 2022 or 2023 by the Director of Nursing (DON). During an interview on 07/16/2026 at 10:20 AM, the Infection Preventionist (IP) stated it had been a little over a year since the last N95 fit testing was completed. During an interview on 07/16/2026 at 1:36 PM, the Director of Nursing (DON) stated N95 fit testing used to be done annually at the facility. The DON stated they did not have much knowledge of the policy or guidance on N95 fit testing. The DON stated the last N95 fit testing was conducted around the time they took over in March of 2023. During an interview on 07/16/2026 at 2:39 PM, the Administrator stated she expected the guidelines to be followed, so she expected N95 fit testing to be done annually. 2. A facility policy titled, Urinary Catheter Infection Prevention Policy Nursing & Infection Prevention, dated 07/2026 revealed, Infection prevention measures are to always be in use and practice with the insertion and maintenance of indwelling catheters. The section of the policy titled, 4. Maintenance specified, Maintaining a closed, continuously sterile drainage system is essential. Bacteria may enter through collection ports and/or migrate from the periurethral area. An admission Record revealed the facility admitted Resident #64 on 07/30/2021. According to the admission Record, the resident had a medical history that included diagnoses of senile degeneration of the brain, urinary tract infection, retention of urine, and benign prostatic hyperplasia with lower urinary tract symptoms. A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 04/10/2026, revealed Resident #64 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS assessment also indicated the resident had an indwelling urinary catheter. Resident #64's Care Plan Report, last reviewed 06/05/2026, included a focus area that indicated Resident #64 had a urinary catheter and diagnosis of urinary retention. Resident #64's Order Summary Report with active orders as of 07/14/2026 revealed an order started on 06/22/2023 for an indwelling urinary catheter. An observation on 07/13/2026 at 11:23 AM revealed Resident #64 was seated in a recliner chair with their indwelling urinary catheter bag attached to a trash can liner and lying on the floor next to the chair. The observation revealed the drainage valve of the catheter bag was in contact with the floor. An observation on 07/14/2026 at (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3:46 PM revealed Resident #64 was seated in a recliner chair with their indwelling catheter attached to a trash can liner and lying on the floor next to the chair. The observation revealed the drainage valve of the catheter bag was in contact with the floor. During a concurrent observation and interview on 07/14/2026 at 3:47 PM, Certified Nursing Assistant (CNA) #1 observed Resident #64's indwelling catheter bag on the floor and stated the catheter bag should not be on the floor next to the resident's recliner. CNA #1 stated the catheter bag would normally be hung on something; however, Resident #64's recliner chair did not have anything to secure the catheter bag hook. During a concurrent observation and interview on 07/14/2026 at 3:51 PM, Licensed Practical Nurse (LPN) #2 observed Resident #64's indwelling catheter bag on the floor and stated she thought the catheter bag was on the floor because the hook on the catheter drainage bag had broken. LPN #2 stated Resident #64's indwelling catheter bag placed on the floor would be potential for infection due to the possibility of bacteria entering into the catheter from the floor. During an interview on 07/14/2026 at 3:52 PM, Certified Nursing Assistant (CNA) #3 stated he was assigned to Resident #64's care; however, he had not yet been in the room to notice the indwelling urinary catheter bag on the floor. CNA #3 stated the catheter bag should not be on the floor. During an interview on 07/16/2026 at 10:56 AM, the Infection Preventionist (IP) stated Resident #64's indwelling urinary catheter bag should not be on the floor. She stated staff had been educated that it could pose a potential for infection; however, she was unsure why the resident's indwelling catheter was observed on the floor. During a follow-up interview on 07/16/2026 at 12:48 PM, the IP stated an indwelling urinary catheter drainage bag should not be hung on a trash can due to potential contamination and infection. During an interview on 07/15/2026 at 4:20 PM, the Director of Nursing (DON) stated the facility previously utilized a knitted bag to prevent the residents' catheter bags from being on the floor; however, he was unsure why that was stopped. The DON stated he expected the drainage bag to have been hung in an alternate location off the floor to prevent infection.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, record review, and facility policy review, the facility failed to ensure a Level I Preadmission Screening and Resident Review (PASARR) accurately reflected the presence of a serious mental illness diagnosis for 1 (Resident #10) of 1 resident reviewed for PASARR requirements. Findings included: An undated facility policy titled, Preadmission Screening for Individuals with a Mental Disorder/Intellectual Disability (PASARR), revealed, Purpose: Ensure each resident in a nursing facility is screened for a mental disorder (MD- also referred to as mental illness) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs. The policy also indicated, The initial screening is referred to as a Level I identification of individuals with MD or ID and is completed prior to admission to the facility. The purpose of the Level I pre-admission screening is to identify individuals who have or may have MD/ID or related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility. An admission Record revealed the facility admitted Resident #10 on 05/01/2025. According to the admission Record, the resident had a medical history that included a secondary admission diagnosis of recurrent unspecified major depressive disorder with an onset date of 05/01/2025. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2025, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was not currently considered by the state level II PASARR process to have serious mental illness. An Oklahoma Health Care Authority Nursing Facility Level of Care Assessment for Resident #10's 05/01/2025 admission, revealed the section addressing Level I PASARR screening was completed to reflect that Resident #10 did not have a diagnosis of serious mental illness. The resident's diagnosis of recurrent unspecified major depressive disorder was not reflected. During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 07/15/2026 at 2:00 PM, the DON stated the PASARR for Resident #10 was completed by the previous DON. He stated the diagnosis of major depressive disorder was present on admission and should have been included on the Level I PASARR. During an interview on 07/16/2026 at 9:00 AM, State PASARR Representative (Rep) #13 stated Resident #10's diagnosis of major depressive disorder was required to be indicated on the PASARR. He stated the major depressive disorder was not communicated to his office. During an interview on 07/16/2026 at 9:33 AM, State PASARR Rep #12 stated Resident #10's diagnosis of recurrent unspecified major depressive disorder should have been reflected on their Level I PASARR. During an interview on 07/16/2026 at 1:12 PM, the DON stated he expected PASARRs to be completed according to regulations prior to admission and accurately with all diagnoses. During an interview on 07/16/2026 at 1:41 PM, the Administrator (ADM) stated she expected PASARRs to be completed prior to admission or the day of and communicate all diagnoses and medications to the state PASARR office. She stated the purpose of the pre-admission screening was to decide the level of care needed and if a resident was appropriate for the facility setting.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure daily staff postings included the resident census on 3 of 3 days that daily staff postings were observed. In addition, the facility failed to maintain the posted daily nurse staffing data for 18 of 18 months. Findings included: An observation on 07/13/2026 at 3:00 PM revealed a whiteboard in the front lobby of the facility that reflected the daily staffing assignments but not the resident census. An observation on 07/14/2026 at 6:00 PM revealed the whiteboard in the front lobby reflected the daily staffing assignments but not the resident census. An observation on 07/15/2026 at 2:00 PM revealed the whiteboard in the front lobby reflected the daily staffing assignments but not the resident census. During an interview on 07/15/2026 at 2:20 PM, the Administrator (ADM) stated the facility did not have a policy on the required daily staff postings. The ADM stated the facility had a whiteboard next to the front nurses' station that gave the date and what staff were on duty and what units each staff member was assigned. She stated the facility did not retain a copy of the daily staff postings other than what was on the whiteboard each day. The ADM verified the whiteboard did not include the daily resident census and could not be retained, because the whiteboard was changed daily according to the assignments.		

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to ensure beneficiary notices were completed with resident name and services provided for informed decision making for 3 (Residents #72, #77, and #78) of 3 sampled residents reviewed for beneficiary notices. Findings included: A facility policy titled, Advance Beneficiary Notices, dated 08/22/2022, indicated, It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. The Centers for Medicare and Medicaid Services (CMS) document titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (2024) indicated in the section, Completing the SNF ABN that, The SNF ABN has the following 4 [four] sections for completion: 1. Header 2. Body 3. Option Boxes 4. Signature and Date. The instructions also specified, B. Patient's Name: SNFs [skilled nursing facilities] must enter the first and last name of the patient receiving the notice, and a middle initial should be entered if there is one on the patient's Medicare card. The instructions indicated, B. ?Care' Section: In this section, the SNF utilizes the appropriate check boxes to indicate that care that it believes may or won't be covered by Medicare. These include Physical Therapy, Occupational Therapy, Daily Skilled Nursing Care and Other. If Other is checked, the SNF must enter the exact nature of the service that had previously been provided. The description must be written in plain language that the patient can understand. The undated CMS document titled, Notice Instructions for the Detailed Explanation of Non-Coverage (DENC) CMS-10124 indicated, Patient's Name: Fill in the beneficiary's/enrollee's first and last name. Member number: Fill in the beneficiary's/enrollee's medical record or identification number. The beneficiary's/enrollee's Medicare number must not be used. {Insert type}: Insert the kind of service being terminated, i.e. [id est - that is], skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice. 1. A SNF [Skilled Nursing Facility] Beneficiary Notification Review form completed by the facility indicated that Resident #77's Medicare Part A skilled services episode start date was 03/02/2026, the last covered day of Part A service was 05/14/2026, and that the facility initiated the discharge from Part A services when the resident's benefit days were not exhausted. The SNF Beneficiary Notification Review indicated the facility provided Resident #77 a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (Centers for Medicare and Medicaid Services [CMS] Form 10055) and a Notice of Medicare Non-Coverage (NOMNC) (CMS Form 10123). Resident #77's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) dated 03/02/2026 indicated that beginning 03/02/2026, the resident may have to pay out of pocket for this care. The form indicated the resident selected Option 1 (for the daily care listed above to be provided and for Medicare to be billed for an official decision on payment); however, the types of care for which the resident might have to pay out of pocket were not documented on the form. Additionally, the field designated for documentation of the resident's name was blank, and the resident's signature, dated 03/02/2026, was not fully legible, making it difficult to confirm for which resident the form was completed Resident #77's Notice of Medicare Non-Coverage form, signed 03/11/2026, indicated the resident's Part A services would end on 05/19/2026 at midnight. The Patient Name and Patient Number fields on the form were blank. The section of the form designated for documentation of the services for which coverage was ending was left blank. 2. A SNF [Skilled Nursing Facility] Beneficiary Notification Review form completed by the facility indicated that Resident #78's Medicare Part A skilled services episode start date was 03/02/2026, the last covered day of Part A service was 04/24/2026, and that the facility initiated the discharge from Part A services when the resident's benefit days were not exhausted. The SNF Beneficiary Notification Review indicated the facility provided Resident #77 a Skilled Nursing Facility (continued on next page)		

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Advanced Beneficiary Notice (SNF ABN) (Centers for Medicare and Medicaid Services [CMS] Form 10055) and a Notice of Medicare Non-Coverage (NOMNC) (CMS Form 10123). Resident #78's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) dated 03/02/2026 indicated that beginning 03/02/2026, the resident may have to pay out of pocket for this care. The form indicated the resident selected Option 1 (for the daily care listed above to be provided and for Medicare to be billed for an official decision on payment); however, the types of care for which the resident might have to pay out of pocket were not documented on the form. Additionally, the field designated for documentation of the resident's name was blank. Resident #78's Notice of Medicare Non-Coverage, signed 04/21/2026, indicated the resident's Part A services would end on 04/24/2026 at midnight. The Patient Name and Patient number fields were blank. The section of the form designated for documentation of the services for which coverage was ending was left blank. 3. A SNF [Skilled Nursing Facility] Beneficiary Notification Review form completed by the facility indicated that Resident #72's Medicare Part A skilled services episode start date was 06/01/2026, the last covered day of Part A service was 06/26/2026, and that the facility initiated the discharge from Part A services when the resident's benefit days were not exhausted. The SNF Beneficiary Notification Review indicated the facility provided Resident #72 a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (Centers for Medicare and Medicaid Services [CMS] Form 10055) and a Notice of Medicare Non-Coverage (NOMNC) (CMS Form 10123). Resident #72's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) dated 06/01/2026 indicated that beginning 06/01/2026, the resident may have to pay out of pocket for physical therapy and daily skilled nursing care. The form indicated the resident selected Option 1 (for the physical therapy and daily skilled nursing care to be provided and billed to Medicare for an official decision on payment). The field designated for documentation of the resident's name was blank Resident #72's Notice of Medicare Non-Coverage, signed 06/23/2026, indicated the resident's Part A services would end on 06/26/2026 at midnight. The Patient Name and Patient number fields were blank. The section of the form designated for documentation of the services for which coverage was ending was left blank. During an interview on 07/16/2026 at 9:31 AM, the Business Office Manager (BOM) stated he was responsible for the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form, and the Assistant Director of Nursing (ADON) completed the Notice of Medicare Non-Coverage forms. The BOM stated the SNF ABN form was provided upon admission on ce they talked with the resident or their family and started the admission packet, went over resident rights, went over the number of skilled days and the number of days approved, went over therapy if applicable, and got the resident's intentions for discharge or if they would remain in the facility. The BOM stated the importance was to inform the family what the steps might be like with Medicare and to give them information. The BOM stated it would be important to have a resident's name on the form. The BOM stated the forms not having the residents' names was an oversight on his part because he had all the forms in a folder. The BOM stated Resident #77's SNF ABN form was not complete without the resident's name and the services provided. The BOM stated it was the same for Resident #78; the SNF ABN form was not complete. The BOM stated Resident #72's SNF ABN form should have the resident's name on it but did not. During an interview on 07/16/2026 at 10:01 AM, the ADON stated the Notice of Medicare Non-Coverage form was provided 48-72 hours before discharge. The ADON stated the importance was to notify the residents their benefits were ending and for discharge planning. The ADON stated Resident #77's Notice of Medicare Non-Coverage form should have the resident's name on it. The ADON stated he was not aware that the information that he went over verbally was supposed to go on the form. The ADON stated Resident #78's Notice of Medicare (continued on next page)		

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Non-Coverage form did not have the resident's name, and the services provided were not specified on the form. The ADON stated Resident #72's Notice of Medicare Non-Coverage form did not contain the resident's name and did not provide the details of the services provided for the resident to make an informed decision. The ADON stated none of those Notice of Medicare Non-Coverage forms were complete. During an interview on 07/16/2026 at 1:25 PM, the Director of Nursing (DON) stated the purpose of the beneficiary notices was to let the residents or family know the services they had been receiving were about to end and to provide information regarding the appeal process if they felt they were being discharged too soon. The DON stated the form should include the resident's name. The DON stated the form should contain the details of services provided so the residents or family could make an informed decision. The DON reviewed the forms for Residents #72, #77, and #78 and stated none of the forms contained the name of the resident for whom the form was completed, and they did not contain details to enable the residents to make an informed decision. The DON stated he expected the Notice of Medicare Non-Coverage forms to be completed thoroughly. During an interview on 07/16/2026 at 2:45 PM, the Administrator stated she expected the beneficiary notices to be thoroughly completed, including the resident's name and details of the services provided. The Administrator stated the importance of the beneficiary notice form was for the residents to know what those benefits were being used for. The Administrator reviewed each resident's form and stated Resident #78's forms were not complete and thorough, and without the resident name, that while the person providing the form may know who the form was for, she would not. The Administrator stated Resident #77's forms were not complete and thorough. The Administrator stated Resident #72's Notice of Medicare Non-Coverage was not complete.		