STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375366	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Nursing Center	1503 West Har-Ber Road Grove, OK 74344

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure appropriate respiratory services were provided for 2 (Resident #16 and Resident #34) of 3 residents reviewed for respiratory services. Specifically, the facility failed to ensure Resident #16's supplemental oxygen use was consistently documented in their medical record and failed to ensure Resident #34's Non-Invasive Ventilator (NIV) settings and supplemental oxygen use were reflected in the resident's electronic medical record Findings included: A facility policy titled, CPAP [continuous positive airway pressure]/BiPAP [bilevel positive airway pressure]/Non-Invasive Ventilator Support, revised 03/2015, indicated, 2. Review the physician's order to determine the order is present. The policy continued, under, Steps in the Procedure, included, 8. Set mode, Machine settings on the machine, as prescribed and indicated 9. Holding the mask to the resident's face, turn on the machine and allow him/her to become acclimated to the pressure. 10. Once the resident is acclimated, secure mask on his/her face. a. The mask should fit firmly but does not need to be airtight. b. Placing the mask on too tightly increases the chance of aspiration and skin breakdown. 11. Connect supplemental oxygen (Note: Connect oxygen after the CPAP machine has been turned on and disconnect before it has been turned off.) and adjust flow rate as prescribed. 12. Monitor the oxygen saturation of the resident. 1. An admission Record revealed the facility admitted Resident #16 on 02/16/2026 and readmitted the resident on 05/18/2026. According to the admission Record, the resident had a medical history that included chronic obstructive pulmonary disease (COPD) and sleep apnea. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2026, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. The MDS indicated that the resident had an active diagnosis of COPD. Resident #16's Care Plan Report included a focus area initiated 05/26/2026, that indicated the resident had a diagnosis of sleep apnea. Interventions directed staff to provide oxygen as ordered by the physician (initiated 05/26/2026). Resident #16's Care Plan Report included a focus area initiated 05/26/2026, that indicated the resident had a diagnosis of COPD. Interventions directed staff to monitor the resident's breathing for increased dyspnea on exertion (initiated 05/26/2026), provide oxygen as ordered by the physician (initiated 05/26/2026), and obtain vital signs and pulse oxygen saturation per physician orders (initiated 05/26/2026). Resident #16's Progress Notes revealed a Communication-Physician note dated 05/26/2026 at 1:53 AM that indicated the resident returned from the emergency room (ER), and that the ER nurse reported the resident may need oxygen at night at 1 liter per minute (L/min). Resident #16's Order Recap [Recapitulation] Report for the timeframe from 02/16/2026 through 06/01/2026, contained an order, dated 05/26/2026 that indicated the resident may wear oxygen at 1L/min at bedtime. Resident #16's May 2026 Treatment Administration Record (TAR) revealed no transcription of the resident's supplemental oxygen order. Resident #16's June 2026 TAR revealed no transcription of the resident's supplemental oxygen order prior to 06/03/2026. During a concurrent observation and interview on 06/01/2026 at 11:00 AM, an oxygen concentrator was observed between Resident #16's chair and bed with the oxygen tubing lying on top of the machine. Resident #16 stated they wore oxygen at night and when taking naps and had started wearing oxygen about a week prior. During an interview on 06/03/2026 at 1:34 PM, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse (LPN) #2 stated oxygen use was usually documented on the medication administration record (MAR) and oxygen saturations on the TAR but confirmed that Resident #16 did not have oxygen monitoring on the TAR, only an order to change the oxygen tubing. During an interview on 06/03/2026 at 3:07 PM, the Director of Nursing (DON) stated the nurse that entered the order for the oxygen did not click the button for it to show up on the TAR, so the use of the supplemental oxygen had not been documented for Resident #16. 2. An admission Record revealed the facility admitted Resident #34 on 10/25/2023 and readmitted the resident on 12/26/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues) and paroxysmal (sudden or recurrent) atrial fibrillation (irregular heartbeat). A quarterly MDS, with an ARD of 05/18/2026, revealed Resident #34 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident received oxygen therapy and non-invasive mechanical ventilation. Resident #34's Care Plan Report did not include a focus area for respiratory care related to NIV or oxygen therapy. There were no interventions directing staff on the resident's use of NIV or oxygen therapy. Resident #34's Non-Invasive Prescription dated 01/09/2026 indicated the resident had orders to receive non-invasive ventilation with pressure support between 6 centimeters of water pressure (cmHˆO) (minimum) and 16 cmHˆO (maximum), backup rate of 20 breaths per minute, and oxygen bleed-in at 3 liter per minute (or the resident's current prescribed oxygen flow rate) when using NIV. Resident #34's Order Recap [Recapitulation] Report for the timeframe from 12/26/2025 through 06/03/2026 included an order to apply NIV at bedtime and remove in the morning related to chronic respiratory failure with hypoxia, assess lung sounds, and gastrointestinal symptoms, dated 01/12/ 2026. The Order Recap Report did not specify the NIV settings or the oxygen flow rate. The Order Recap Report further revealed no physician order for continuous or as-needed (PRN) supplemental oxygen use prior to 06/03/2026. Resident #34's June 2026 TAR revealed documentation of the NIV being applied and removed daily, but no evidence of the NIV settings. The June 2026 TAR also revealed no evidence of supplemental oxygen use. An observation on 06/01/2026 at 10:30 AM revealed an NIV machine on Resident #34's over-the-bed (OTB) table, with the mask lying on top of the machine. During an interview on 06/03/2026 at 1:38 PM, Resident #34 stated they tried to use a CPAP machine (as they called it) every night but did not know what the settings were or how many liters of oxygen were prescribed when using the device. Resident #34 stated they were supposed to be on 2 liters when using the nasal cannula. An observation on 06/02/2026 at 9:58 AM, revealed Resident #34 was seated in the dining room wearing oxygen via [by way of] nasal cannula hooked to a portable oxygen tank set at 2 L/min. An observation on 06/02/2026 at 11:56 AM revealed Resident #34 remained in the dining area wearing oxygen at 2 L/min. During an interview on 06/03/2026 at 1:55 PM, LPN #2 stated staff were supposed to have orders for oxygen use and NIV therapy, but she was not sure what those orders included. LPN #2 confirmed Resident #34's medical record did not contain a physician order for the use of PRN or continuous supplemental oxygen and that the NIV order did not include settings or oxygen flow rate. During an interview on 06/04/2026 at 9:37 AM, LPN #4 stated orders were required for oxygen use, including liters per minute and when to use it. She reviewed Resident #34's medical record and confirmed the resident did not have an order for supplemental oxygen prior to 06/03/2026, despite being on supplemental oxygen for some time. During an interview on 06/04/2026 at 11:08 AM, the DON stated the residents needed to have orders for the use of oxygen, and the order should include the rate of flow and the type of cannula or mask to use and when to use it. She stated she was not sure why Resident #34 did not have an order for their oxygen. She thought it might not have been reinstated when they came back from the hospital. During an interview on 06/03/2026 at 2:44 PM, the DON stated every resident that received supplemental oxygen should have a physician order, and oxygen use should be documented on the TAR. During an interview on 06/04/2026 at 1:01 PM, the Administrator stated supplemental oxygen use required a physician order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, facility policy review, and review of manufacturer package insert, the facility failed to ensure expired medications were discarded from 2 (400 and 500 Hall medication carts) of 3 medication carts reviewed for medication storage. Findings included: A facility policy titled, Storage of Medications, revised 04/2007, indicated, 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. The policy continued, 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. A package insert for latanoprost ophthalmic solution revised in 08/2011, indicated, Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees C [Celsius] (77 degrees F [Fahrenheit]) for 6 weeks. An observation on 06/02/2026 at 3:39 PM of the 400 Hall medication cart with Certified Medication Aide (CMA) #9 revealed a bottle of Vitamin B12 500 micrograms with an expiration date of 04/04/2025 for Resident #42. An observation on 06/02/2026 at 3:41 PM of the 500 Hall medication cart revealed the following:-a box of anti-diarrheal tablets with an expiration date of April 2026;-a bottle of latanoprost eye drops (used for glaucoma) for Resident #34 with open date of 04/16/2026;-a bottle of latanoprost eye drops for Resident #15 with open date of 04/17/2026;-a bottle of vibegron (used to treat overactive bladder) 75 milligram tablets for Resident #26 with an expiration date on the label of 01/10/2026; and-a bottle of Metamucil powder with an expiration date on the label of 05/2026. During an interview on 06/02/2026 at 3:41 PM, CMA #9 stated it was each staff member's responsibility to keep medication carts clean and ensure expired medications were removed. CNA #9 stated he thought latanoprost was good for 30 days after it was opened. He could not explain why the expired medications remained on the cart after their discard dates. During an interview on 06/04/2026 at 9:22 AM, CMA #6 stated all medication aides were responsible for keeping the medication carts clean and organized and for removing expired medications. She stated she checked for expired medications and was not aware expired medications were on the carts and stated they must have missed them. During an interview on 06/04/2026 at 9:32 AM, CMA #10 stated eye drops should be discarded 30 days after opening. She stated that open dates should be written on all products. CMA #10 stated medication carts should be checked before the end of the shift to reorder, clean, and check for expired medications. She also stated she usually worked on the 500 Hall cart and could not explain why expired medications were found on the cart. During an interview on 06/04/2026 at 9:37 AM, Licensed Practical Nurse (LPN) #4 stated medication carts should be inspected for expired medications. She was not sure how often, but at least once a week. During an interview on 06/04/2026 at 10:36 AM, the Pharmacy Consultant stated he visited the facility once a month to check each resident's record, performed a medication pass observation, and inspected the medication carts for expired medications, focusing on one cart during each visit. He stated that latanoprost was good for 42 days after it was opened. He stated they tried their best, and he expected the staff to also check the carts when he was not there. He confirmed the medications were expired and stated it was unfortunate that the medications were not removed from the cart after they expired. During an interview on 06/04/2026 at 11:08 AM, the Director of Nursing (DON) stated that medication aides were responsible for checking their carts during every shift to ensure expired medications were removed. She stated she was not sure how long latanoprost was good, but 30 days was the standard for eye drops. She stated the staff should date the medication when opened and discard after the date required. She confirmed expired medications should not be on the carts and said she could not explain why they were present. During an interview on 06/04/2026 at 1:01 PM, the Administrator (ADM) stated that the medication aides should check their carts daily, and once a month the pharmacist should come and check for expired medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on facility policy review, observation, interview, facility document review, and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable disease and infections when staff failed to do the following:- Ensure hand hygiene was completed between residents, which affected 3 (Resident #62, Resident #67 and Resident #21) of 5 residents observed during meal service.- Clean and store respiratory equipment for 2 (Resident #34 and Resident #16) of 3 residents reviewed for respiratory care.- Ensure the emergency cart was clean and suction tips were not open and exposed for 1 of 1 emergency carts observed. Findings included: 1. A facility policy titled, Handwashing/Hand Hygiene, revised August 2015, indicated, The facility considers hand hygiene the primary means to prevent the spread of infections. The policy revealed, 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations, which included l. After contact with objects (e.g. [exempli gratia, for example], medical equipment) in the immediate vicinity of the resident; and p. Before and after assisting a resident with meals. An admission Record revealed the facility admitted Resident #62 on 05/29/2026. According to the admission Record, the resident had a medical history that included a diagnosis of metabolic encephalopathy (a brain dysfunction related to metabolism). An admission Record revealed the facility admitted Resident #67 on 05/31/2026. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. An admission Review revealed the facility admitted Resident #21 on 05/10/2026. According to the admission Record, the resident had a medical history that included a diagnosis of weakness. An observation on Hall 300 during the meal service on 06/01/2026 at 12:42 PM revealed Certified Nursing Aide (CNA) #1 brought a meal tray to Resident #62's room from a rolling metal cart in the hallway. She placed the meal tray in the resident's room. The CNA took the resident's used cup out of their room and placed it on the bottom shelf of the metal meal service cart. She moved the resident's glasses and touched the resident's walker twice. She then shut the door after exiting the room. CNA #1 did not sanitize or wash her hands after exiting the room. She then entered Resident #67's room with a meal tray and set the resident's meal tray down. The CNA then proceeded to Resident #21's room with a meal tray. She opened the door by the handle, delivered the meal tray, and shut the door behind her. During the observation, CNA #1 did not sanitize or wash her hands between each resident. During an interview following the observation, CNA #1 stated staff should wash or sanitize their hands when exiting each resident's room if anything in the environment was touched. She stated she did not sanitize her hands between each resident. She stated she generally kept hand sanitizer in her pockets, but she did not that day. She stated she should have sanitized her hands between each resident. On 06/03/2026 at 1:25 PM, the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) stated that if staff were moving residents' equipment, then staff should be using hand sanitizer between residents. On 06/04/2026 at 8:19 AM, the Director of Nursing (DON) stated that staff should use hand sanitizer or wash their hands prior to entering and exiting resident rooms. She stated that if the staff handled any resident equipment or personal belongings, the staff should sanitize their hands. On 06/04/2026 at 12:46 PM, the Administrator (ADM) stated that at the minimum, staff should use hand sanitizer between each resident when going in and out of the rooms. 2. A facility policy titled, CPAP [continuous positive airway pressure]/BiPAP [bilevel positive airway pressure]/Non-Invasive Ventilator (NIV) Support, revised 03/2015, specified, General Guidelines for Cleaning included 4. Machine Cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed; 5. Humidifier (if used), which included a. Use clean, distilled water only in the humidifier chamber; b. Clean humidifier weekly and air dry; and c. To disinfect, place vinegar-water solution (1:3) in clean humidifier. Soak for 30 minutes and rinse thoroughly. The policy continued, 6. Filter cleaning, which included a. Rinse washable filter under running water once a week to remove dust and debris. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Replace this filter at least once a year; and b. Replace disposable filters monthly. The policy continued, 7. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow to air dry between uses; and 8. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. An admission Record revealed the facility admitted Resident #34 on 10/25/2023 and readmitted the resident on 12/26/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic respiratory failure with hypoxia (a deficiency in the amount of oxygen reaching the tissues) and paroxysmal (sudden or recurrent) atrial fibrillation (irregular heartbeat). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/18/2026, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident received oxygen therapy and non-invasive mechanical ventilation. Resident #34's Care Plan Report revealed that it did not include a focus area for respiratory care related to NIV or oxygen therapy. There were no interventions directing staff on the cleaning or storage of the NIV mask or oxygen tubing. Resident #34's Order Recap [Recapitulation] Report, for the timeframe from 12/26/2025 through 06/03/2026 included the following orders:-Apply NIV at bedtime and remove in the morning related to chronic respiratory failure with hypoxia, assess lung sounds, and gastrointestinal symptoms, if yes, notify the physician, dated 01/12/2026.-Change oxygen tubing weekly one time a day on Saturday, dated 04/27/2026.The Order Recap Report revealed no orders for the cleaning or storing of the NIV equipment, including the machine, tubing, or the mask. Resident #34's May 2026 Treatment Administration Record [TAR] revealed staff documented that oxygen tubing was changed according to the order on 05/30/2026. The TAR revealed no record of documentation for cleaning or storing the NIV equipment, including the mask, tubing, or the machine. During an interview on 06/03/2026 at 1:38 PM, Resident #34 stated they tried to use a CPAP machine (as the resident called it) every night and had never seen the staff clean the mask. Resident #34 stated that staff normally placed oxygen tubing on a chair when not in use and that no one had told them differently. An observation on 06/01/2026 at 10:30 AM revealed an NIV machine on Resident #34's over-the-bed (OTB) table, with the mask lying on top of the machine. Dried debris was visible inside the mask. An observation on 06/02/2026 at 8:30 AM revealed the NIV mask was on top of Resident #34's machine with dried debris on the inside of the mask, and an oxygen cannula dated 05/03/2026 was tangled with other tubing and lying on the floor. No storage bag was present. An observation on 06/02/2026 at 12:03 PM revealed that the NIV mask in Resident #34's room was still in the same location, with visible dried debris inside the mask. An observation on 06/03/2026 at 8:24 AM revealed Resident #34's NIV mask was on top of the machine with dried debris in the mask. The oxygen tubing was wadded together and lying on the floor beneath the OTB table. During an observation and interview on 06/03/2026 at 1:35 PM with Licensed Practical Nurse (LPN) #2 and Registered Nurse (RN) #3 in Resident #34's room, the resident's oxygen cannula was lying on the bed, and the NIV mask was draped over the machine. RN #3 picked up the mask and confirmed there was dried debris inside. LPN #2 stated that she had not cleaned the mask that morning and was unaware of cleaning or storage procedures for NIV masks. She stated that she had not been trained in their use and had only been working at the facility for seven days. During an interview on 06/04/2026 at 9:37 AM, LPN #4 stated that NIV masks should be wiped out every morning and air-dried before being placed on the machine. An admission Record revealed the facility admitted Resident #16 on 02/16/2026 and readmitted the resident on 05/18/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and sleep apnea. An admission MDS, with an ARD of 05/25/2026, revealed Resident #16 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident had an active diagnosis of COPD. Resident #16's Care Plan Report included a focus area initiated 05/26/2026, that indicated the resident had a diagnosis of sleep apnea. Interventions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directed staff to provide oxygen as ordered by the physician (initiated 05/26/2026). Resident #16's Care Plan Report included a focus area initiated 05/26/2026, that indicated the resident had a diagnosis of COPD. Interventions directed staff to monitor the resident's breathing for increased dyspnea on exertion (initiated 05/26/2026), provide oxygen as ordered by the physician (initiated 05/26/2026), and obtain vital signs and pulse oxygen saturation per physician orders (initiated 05/26/2026). Resident #16's Order Recap Report, for the timeframe from 02/16/2026 through 06/01/2026, included an order, dated 05/26/2026, that indicated the resident may wear oxygen at 1 liter per minute (L/min) at bedtime. The order did not include additional directions related to the use of supplemental oxygen. An observation on 06/01/2026 at 11:00 AM revealed an oxygen concentrator between Resident #16's chair and bed, with the oxygen tubing lying on top of the machine. During an interview at the time of the observation, Resident #16 stated they received supplemental oxygen at night and during naps and had started using it about a week earlier. Resident #16 stated that they placed the tubing on the table or machine when not in use because no one had told them to do otherwise, and staff did the same. An observation on 06/02/2026 at 8:28 AM revealed Resident #16 was not in the room. The oxygen concentrator's power was off, and the oxygen tubing was lying across the machine with the cannula hanging behind the machine. No storage bag was present. An observation on 06/02/2026 at 12:05 PM revealed the oxygen tubing remained in the same location on the concentrator. An observation on 06/03/2026 at 8:22 AM revealed the oxygen tubing was lying across the over-the-bed table and hanging down the side. During an observation and interview on 06/03/2026 at 1:33 PM with LPN #2 and RN #3 in Resident #16's room, the oxygen tubing was draped across the table. RN #3 stated it should not be stored that way and should be on top of the concentrator. During an interview on 06/03/2026 at 1:30 PM, LPN #2 stated she was not sure where the oxygen tubing was supposed to be stored when not in use and thought it was to be kept on the bedside table. She stated it was the same for an NIV mask. During an interview on 06/03/2026 at 1:32 PM, RN #3 stated that she wadded the oxygen tubing and placed it either under the concentrator handle or on top of a portable tank regulator, making sure it did not touch the floor. She also stated they were supposed to rinse out an NIV mask, put it on a dry paper towel, and leave it there to air dry until use that night. During an interview on 06/04/2026 at 9:18 AM, Certified Nurse Aide (CNA) #5 stated oxygen tubing was supposed to be wrapped and stuck under the handle of the concentrator when not in use. She stated that for portable tanks, the oxygen tubing was to be wrapped around and put on top of the regulator to keep it off the floor, and if it was on the floor or dirty, it should be replaced. During an interview on 06/04/2026 at 11:08 AM, the Director of Nursing (DON) stated that NIV masks should be wiped out with warm soapy water, dried, and stored in a bag. She stated that oxygen tubing should be rolled up and placed in a net bag on the concentrator. During an interview on 06/04/2026 at 1:01 PM, the Administrator stated that respiratory equipment should be stored in a bag when not in use. She stated that nurses should clean NIV masks, but she was not sure of the process. 3. The facility's Emergency Cart Checklist documents included Suction Tubing, AMBU [artificial manual breathing unit] Bags, and Suction Machine. A checklist dated 05/21/2026 revealed that staff documented all sections as Good. During an observation on 06/02/2026 at 2:24 PM, an emergency cart by the nurses' station had a suction machine on top. A sticky brown substance had spilled on the top of the cart and onto the plastic bag covering the suction machine. A suction tip was attached to tubing on the machine and was lying in the brown substance unwrapped and exposed. On 06/03/2026 at 10:10 AM, accompanied by the Director of Nursing (DON), the emergency cart was rechecked. The DON cut the lock to inspect. Two manual resuscitators were present, the suction machine was covered with a clean plastic bag, and the top of the cart was free from the sticky substance. However, the suction tubing was connected to the suction machine, with a suction tip removed from its package lying on the cart surface, not in sterile packaging. The DON immediately removed the suction tip and replaced it with a sealed, sterile suction tip (not connected). During an interview on 06/04/2026 at 9:37 AM, Licensed Practical Nurse (LPN) #4 stated that the DON was responsible for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the emergency cart. She stated that the suction tip should be left in the package and not opened until use. During an interview on 06/03/2026 at 10:10 AM, the DON stated that the suction tip should not be removed from the package until it was ready to be used to maintain infection control. During an interview on 06/04/2026 at 11:08 AM, the DON stated the emergency cart was checked monthly and after each use by the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) or her, if the ADON/IP was not there. During an interview on 06/04/2026 at 1:01 PM, the Administrator stated that the emergency cart should be maintained by the DON, and it needed to be kept clean. She stated that the suction tip should not be open until it is used.

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Grove Nursing Center	1503 West Har-Ber Road Grove, OK 74344

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to treat residents in a manner that maintained or enhanced the resident's dignity and respect in full recognition of his or her individuality for 2 (Resident #15 and Resident #46) of 2 residents reviewed for dignity. Findings included: A facility policy titled, Assistance with Meals, revised July 2017, revealed the section titled, Dining Room Residents: included, 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. Not standing over residents while assisting them with meals. An admission Record revealed that the facility admitted Resident #15 on 01/15/2025. According to the admission Record, Resident #15 had a medical history that included diagnoses of anxiety disorder, unspecified dementia, gastro-esophageal reflux disease, and other recurrent depressive disorders. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/2026, revealed Resident #15 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS indicated that the resident was dependent on staff for all activities of daily living (ADLs). Resident #15's Care Plan Report, revealed a focus area dated 02/06/2026, that indicated the resident required assistance with ADLs. Interventions indicated that the resident required assistance to eat. An admission Record revealed that the facility admitted Resident #46 on 05/11/2026. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's Disease, dementia in other diseases classified elsewhere, and restlessness and agitation. An admission MDS, with an ARD of 05/18/2026, revealed Resident #46 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a SAMS. The MDS indicated that the resident required substantial/maximal assistance with eating. Resident #46's Care Plan Report, revealed a focus area dated 06/19/2026, that indicated the resident required assistance with eating. During an observation on 06/01/2026 at 12:26 PM, Certified Nursing Assistant (CNA) #12 was observed in the facility dining room assisting Resident #15 and Resident #46 with eating while standing between the two residents, instead of providing the assistance from a seated position. During an interview on 06/01/2026 at 12:49 PM, CNA #12 stated that sometimes she sat and sometimes she stood while assisting residents with eating; it depended on the best approach for the resident's needs and how they were seated. CNA #12 stated that she had completed training and refresher courses on providing meal assistance but could not recall what was taught about the best practice for how to provide the assistance. During an interview on 06/03/2026 at 1:18 PM, Registered Nurse (RN) #3 stated her expectation was that the staff would be attentive to the resident's needs and maintain dignity by not standing over the residents during meal assistance. During an interview on 06/03/2026 at 1:27 PM, the Director of Nursing (DON) stated that staff should be sitting next to the resident during meal assistance. During an interview on 06/03/2026 at 1:35 PM, the Administrator (ADM) stated that the staff must be sitting alongside the resident during the meal and they should not stand up and feed the resident.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure 2 (Resident #1 and Resident #22) of 2 residents who had medications at their bedside and were assessed by the interdisciplinary team (IDT) to determine if they were clinically appropriate and safe to self-administer their medications. Findings included: A facility policy titled, Self-Administration of Medications, revised in December 2016, revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy continued, 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medications; and d. Ability to recognize risks and major adverse consequences of his or her medications. 1. An admission Record revealed the facility admitted Resident #1 on 07/02/2025 and re-admitted the resident on 04/15/2026. According to the admission Record, the resident had a medical history that included diagnoses of pneumonia and hypertensive heart disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/22/2026, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. During a concurrent observation and interview in Resident #1's room on 06/01/2026 at 2:59 PM, a bottle of saline nasal spray and a bottle of Afrin nasal spray were on the resident's counter, next to their television. Resident #1 said they brought the medication to the facility when they were admitted . During a concurrent observation and interview in Resident #1's room on 06/04/2026 at 9:01 AM, a bottle of saline nasal spray and Vicks [NAME] Severe nasal spray was on the resident's counter, next to their television. Resident #1 stated that they brought the medications from home, and the facility was aware. The resident further stated they did not tell the staff when they used the medication, and the staff did not provide a way for the resident to track the use of the medications; they just mentally tracked it in their head. Resident #1's Care Plan Report revealed no documentation regarding self-administration of medications. Resident #1's Order Summary Report, with active orders as of 06/04/2026, revealed no order for a nasal spray nor evidence the resident was able to self-administer any medication or keep medication at their bedside. During an interview on 06/04/2026 at 11:15 AM, Licensed Practical Nurse (LPN) #2 stated that she was not aware the medications were in the resident's room, and that the resident did not notify her of any self-administration. The nurse stated she believed Resident #1 could self-administer but said the nasal sprays required a self-administration assessment to make sure the resident was using them correctly. During an interview on 06/04/2026 at 12:39 PM, the Director of Nursing (DON) stated that for a resident to have medication at bedside, they had to pass a self-administration assessment. The assessment was to make sure the resident could properly and safely administer the medication to themself. She stated the residents were given a paper Medication Administration Record (MAR) to fill out when they gave themselves medication, and the MAR was to be uploaded into the chart weekly. The DON stated the facility discouraged the residents from keeping medication at the bedside; however, it was hard to monitor, because the family brought in medications sometimes. 2. An admission Record revealed the facility admitted Resident #22 on 01/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of paroxysmal fibrillation and essential hypertension. Resident #22's quarterly MDS, with an ARD of 05/04/2026, revealed the resident had a BIMS score of 15, which indicated the resident had intact cognition. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in Resident #22's room on 06/01/2026 at 11:43 AM, three bottles of eye drops (two bottles of Refresh Tears and one bottle of Visine) were on the resident's bedside table. During a concurrent observation and interview in Resident #22's room on 06/02/2026 at 2:45 PM, two bottles of Refresh Tears and one bottle of Visine were on the resident's bedside table. Resident #22 stated that they used the eye drops when they needed them and did not tell their nurse when they used the drops. Resident #22 stated they had the eye drops for so long that they could not remember if the facility provided them or if their family member brought the eye drops to the facility. During an observation in Resident #22's room on 06/04/2026 at 8:54 AM, two bottles of Refresh Tears and one bottle of Visine were on the resident's bedside table. Resident #22's Care Plan Report, revealed no documentation regarding self-administration of medications. Resident #22's Order Summary Report, with active orders as of 06/04/2026, contained an order dated 08/08/2025, for artificial tears ophthalmic solution, one drop in both eyes every six hours as needed. The Order Summary Report revealed no evidence that the resident was able to self-administer any medication or keep medication at their bedside. During an interview on 06/04/02026 at 10:31 AM, Certified Nursing Aide (CNA) #13 stated Resident #22 could not self-administer medications, and if they noticed medications at their bedside, they would notify the certified medication aide or the nurse. CNA #13 stated they had not noticed any medications at bedside. During an interview on 06/04/2026 at 11:04 AM, Registered Nurse (RN) #14 stated they had not noticed medications were on Resident #22's bedside table. The nurse reviewed the medications and confirmed the Visine was brought in by the resident's family; however, the Refresh tears were provided by the facility. RN #14 stated there was a process in place to determine self-administration, where staff monitored the resident over a three-day period to make sure they understood how to read the label and when to administer the medications, then a nurse submitted the documentation to the provider for approval. During an interview on 06/04/2026 at 12:39 PM, the DON stated that for a resident to have medication at the bedside, they had to pass a self-administration assessment. The assessment was to make sure the resident could properly and safely administer the medication to themself. She stated the residents were given a paper MAR to fill out when they gave themselves medication, and the MAR was uploaded into the chart weekly. The DON stated the facility discouraged the residents from keeping medication at the bedside; however, it was hard to monitor, because the family brought in medications sometimes. During a telephone interview on 06/04/2026 at 1:25 PM, the Administrator (ADM) stated that residents had to have an order for every medication that came into the building. She stated no medications were allowed at bedside unless the residents were assessed and approved for self-administration, and there were no residents in the building who self-administered medications. The ADM stated that the process for self-administration would be to notify the provider, ensure the resident was cognitively aware and could complete the MAR, and use a lock box to secure the medication.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident room was in good repair and homelike, which affected 2 (Resident #65 and Resident #66) of 4 residents reviewed for environmental concerns. Findings included: A facility policy titled, Quality of Life - Homelike Environment, revised May 2017, indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The policy revealed, 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include, which included a. Clean, sanitary and orderly environment; and c. Inviting colors and decor. 1. An admission Record revealed the facility admitted Resident #65 on 05/29/2026. According to the admission Record, the resident had a medical history that included a diagnosis of heart failure. An admission Record indicated the facility admitted Resident #66 on 05/29/2026. According to the admission Record, the resident had a medical history that included diagnoses of generalized anxiety disorder; depression, unspecified; and adult failure to thrive. An observation of Resident #65's and Resident #66's shared room on 06/01/2026 at 9:54 AM, revealed the walls had several white marks on a blue accent wall, and there were black marks on the white wall. The paint on the white wall had a spot peeling about three inches long by three inches wide in size. During an interview at the time of the observation, Resident #66 stated that their room walls had gashes in them and needed to be painted. During an interview on 06/03/2026 at 2:59 PM, Housekeeper (HK) #15 stated that after a resident moved out of a room, housekeeping staff deep cleaned the room. HK #15 stated that the staff wiped everything down and disinfected everything. He stated that if there was something wrong with the walls or something broken, the housekeeper cleaning the room filled out a maintenance work order form. HK #15 stated that if there were chips in the walls and peeling paint, a maintenance work order needed to be filled out. During an interview on 06/03/2026 at 2:42 PM, the Maintenance Director stated that when residents moved out of a room, the rooms were inspected to see if they needed new paint or repairs. He stated that if the rooms needed repair, housekeeping staff held off before cleaning, and maintenance staff made the necessary repairs. The Maintenance Director stated that there were times when maintenance staff were not aware if one resident left, and another resident moved in unless housekeeping staff reported that the room needed maintenance repairs. The Maintenance Director revealed being the only maintenance staff at the facility. During the interview, an observation of Resident #66's room was made with the Maintenance Director, and the Maintenance Director stated that he saw blue paint, and that it was old paint. He further stated that several rooms had been painted the previous year, but that there had not been enough time during the current year to paint as many rooms. In regard to Resident #66's room, the Maintenance Director stated that there were chips in the wall and scrapes all the way down the wall. The Maintenance Director revealed the room needed to be painted and touched up on the walls. The Maintenance Director revealed that he had not been notified by housekeeping staff that the walls had chipped paint and old paint on the walls. During an interview on 06/04/2026 at 8:19 AM, the Director of Nursing (DON) stated that when a resident moved out, housekeeping staff did a deep clean, and maintenance staff did a check to see if any repairs needed to be made. The DON stated that if repairs were needed, it was expected that the repairs be made. The DON revealed there was a resident in Resident #66's room for eight years prior to Resident #66's admission and during that time, not many changes could be made. The DON revealed that she told nursing staff to make sure the repairs were made to that room prior to moving in a new resident. The DON stated that repairs should have been made prior to putting residents in the room. During an interview on 06/04/2026 at 12:47 PM, the Administrator (ADM) stated that if a room were empty, housekeeping staff came in and deep cleaned the room. She stated that the housekeeping staff should make a list of anything that needed to be repaired. The ADM (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the list of repairs was given to the Maintenance Director. The Administrator stated that the maintenance staff came in and repaired the room, then a new resident would be admitted to the room. The Administrator revealed that she was not aware of the situation with Resident #66's room, and there was no excuse for the room to be in that condition.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on facility policy review, record review, observation, and interview, the facility failed to ensure they developed and implemented comprehensive person-centered care plans for 1 (Resident #5) of 1 resident reviewed for hospice services and 1 (Resident #34) of 3 residents reviewed for respiratory care. Findings included: An undated facility policy titled, Care Plans, Comprehensive Person-Centered, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. The policy revealed, 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy also revealed, 8. The comprehensive, person-center care plan will, which included a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; g. Incorporate identified problem areas; l. Identify the professional services that are responsible for each element of care; and m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels. 1. An admission Record revealed the facility admitted Resident #5 on 04/28/2026. According to the admission Record, the resident had a medical history that included diagnoses of acute on chronic systolic (congestive) heart failure, paroxysmal atrial fibrillation, anxiety disorder, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, major depressive disorder, and obstructive sleep apnea. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2026, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident was receiving hospice care. Resident #5's Care Plan Report revealed no evidence of a focus area, goal, or interventions related to hospice care prior to 06/03/2026. During interview on 06/04/2026 at 8:17 AM, Registered Nurse (RN) MDS #7 stated that she was responsible for developing the comprehensive care plan. She stated that she got resident information from nursing documentation, physician orders, and interviews with staff and the residents, if necessary. During interview on 06/04/2026 at 8:17 AM, RN MDS #8 stated that if a resident was on hospice, they should always have a care plan for it. She stated that when a resident went on hospice, she completed a change of status MDS and reviewed the hospice information. RN MDS #8 stated that she reviewed the orders and updated the care plan. She stated that she shared information with the hospice team and developed their care plan along with the hospice care plan. She stated that MDS staff reviewed the hospice care plans and added what they felt was needed and transferred it over to the comprehensive care plan. She stated that care plans were not reviewed for accuracy after MDS completion. During an interview on 06/04/2026 at 12:39 PM, the Director of Nursing (DON) stated that Resident #5 had been on hospice since the facility admitted them. She stated that the only thing hospice staff did for the resident was provide showers; the facility staff provided everything else. She stated that the process was to make sure that the hospice care plan was scanned in, then the facility staff created their comprehensive care plan. The DON stated that care plan reviews were set based on the care plan review date unless something came up. The DON stated that the care plans were not reviewed for accuracy because the administration did not micromanage. She stated that if something was missed, it would more than likely get caught during the following care plan review. During a telephone interview on 06/04/2026 at 1:25 PM, the Administrator stated that the MDS nurses did all the care plans. The Administrator stated that she made sure that they did not get behind. She stated that there were certain alerts in the electronic health records, but as far as double checking the accuracy of the care plans that MDS staff completed, she was not sure if that was done. 2. An admission Record revealed the facility (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted Resident #34 on 10/25/2023 and readmitted the resident on 12/26/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic respiratory failure with hypoxia (a deficiency in the amount of oxygen reaching the tissues) and paroxysmal (sudden or recurrent) atrial fibrillation (irregular heartbeat). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/18/2026, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident received oxygen therapy and non-invasive mechanical ventilation. Resident #34's Order Recap [Recapitulation] Report, for the timeframe from 12/26/2025 through 06/03/2026 included the following orders:-Apply an NIV [non-invasive ventilation] machine (a machine that helps with breathing by pushing air into the lungs through a mask) at bedtime and remove in the morning related to chronic respiratory failure with hypoxia, assess lung sounds, and gastrointestinal symptoms, if yes, notify the physician, dated 01/12/2026.-Change oxygen tubing weekly one time a day on Saturday, dated 04/27/2026.The Order Recap Report revealed no physician order for supplemental oxygen prior to 06/03/2026. An observation on 06/01/2026 at 10:30 AM revealed an NIV machine was observed on Resident #34's over-the-bed (table, with the mask lying on top of the machine. An observation on 06/02/2026 at 9:58 AM revealed that Resident #34 was seated in the dining room wearing oxygen via nasal cannula hooked to a portable oxygen tank at 2 liters a minute (L/min), and the tank gauge was a quarter full. During an interview on 06/03/2026 at 1:38 PM, Resident #34 stated they tried to use a continuous positive airway pressure (CPAP) machine (as the resident called it) every night. Resident #34 stated they were supposed to be on 2 liters of supplemental oxygen when using the nasal cannula. Resident #34's Care Plan Report revealed that it did not include a focus area for respiratory care related to NIV or oxygen therapy. There were no interventions directing staff on the cleaning or storage of the NIV mask or oxygen tubing, and no interventions regarding the resident's use of oxygen. During an interview on 06/04/2026 at 9:37 AM, Licensed Practical Nurse (LPN) #4 stated care plans should address oxygen use and that MDS staff handled updates to the care plans. During an interview on 06/04/2026 at 8:19 AM, Registered Nurse (RN) MDS #7 stated she mistakenly resolved Resident #34's respiratory care plan when completing the MDS because the resident was refusing the NIV. She stated that she should have updated the care plan to reflect refusal instead of discontinuing it since the resident still required supplemental oxygen during the day and night. During an interview on 06/04/2026 at 8:19 AM, RN MDS #8 stated that the MDS team developed care plans using records, nurse notes, staff/resident interviews, and physician orders, but they did not conduct room observations. RN MDS #8 stated that respiratory conditions, oxygen use, or equipment such as NIV must appear in the care plan. She reviewed Resident #34's plan and confirmed it lacked a respiratory focus area. During an interview on 06/04/2026 at 11:08 AM, the Director of Nursing (DON) stated that if a resident was on supplemental oxygen or used an NIV, it must be care planned as either a standalone focus or integrated into another area. She stated that the MDS staff were responsible for maintaining care plans, and she could not explain why Resident #34's plan lacked a respiratory focus. During an interview on 06/04/2026 at 1:01 PM, the Administrator stated that the use of supplemental oxygen should be included on the care plan, and MDS staff were responsible for the care plans.