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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375384 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/16/2025 |
| NAME OF PROVIDER OR SUPPLIER New Hope Retirement & Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 East Electric Blvd McAlester, OK 74501 | |

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) |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the physical environment was maintained in good repair. The administrator identified 39 residents resided in the facility. Findings: On 07/15/25 at 7:55 a.m., during a tour of the dining room, the ceiling was observed to have multiple ceiling tiles with large brown watermark stains. On 07/17/25 at 3:30 p.m., during a tour of the facility, resident rooms #2, #4, #17, and #28 were observed to have sagging white ceiling tiles. The ceiling tiles had brown watermark stains around and near the air vents. A policy titled Homelike Environment, revised February 2021, read in part, Residents are provided with a safe, clean, comfortable and homelike environment. On 07/17/25 at 3:42 p.m., the maintenance supervisor stated the sagging tiles with brown watermark stains were caused by water leaks from the roof. They stated the facility's roof leaked every time it rained. The maintenance supervisor stated they tried to change out the stained and sagging ceiling tiles often, but the roof needed to be permanently repaired. On 07/17/25 at 4:01 p.m., the administrator stated the facility's roof had leaked since they began employment in February 2024. They stated management was aware, but had not permanently addressed the concern. The administrator stated the physical environment of the facility had not been maintained in good repair.</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed for indwelling urinary catheter care and maintenance for 1 (#2) of 2 residents sampled for indwelling urinary catheters. The administrator identified one resident with an indwelling urinary catheter. Findings: An undated medical diagnosis list showed Res #2 had diagnoses which included retention of urine and congenital bladder neck obstruction. A physician order, dated 08/07/24, showed to change the indwelling urinary catheter every 30 days and as needed and to perform catheter care every shift and as needed. A quarterly assessment, dated 08/21/24, showed Res #2 had a BIMS score of 12 and was cognitively intact. The assessment showed Res #2 had an indwelling urinary catheter. Res #2's care plan was reviewed. There was no documentation for indwelling urinary catheter care and maintenance shown on the care plan. On 07/15/25 at 4:35 p.m., the MDS coordinator stated a comprehensive care plan for urinary catheter care and maintenance had not been developed for Res #2, but should have been.</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and interview, the facility failed to update a resident's care plan after abusive behavior was observed for 1 (#3) of 3 sampled residents reviewed for abuse. The administrator identified 39 residents resided in the facility. A care plan policy, revised March 2022, showed care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The policy showed when possible, interventions addressed the underlying sources of the problem areas, not just symptoms or triggers. The policy showed assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions change. A facility reported incident, dated 04/27/25, showed an allegation of abuse/mistreatment involving Resident #3 and Resident #6. The reported incident showed resident to resident abuse by staff. Immediate separation of residents. Alleged abuser had one on one provided while arrangements being made for behavioral placement. There were no updates to Resident #3's care plan regarding the above incident. A nursing note, dated 04/27/25 at 11:00 a.m., read in part, Resident approached another resident and was seen pushing [them] up to the table and trying to lock the wheelchair and was instructed to move on and leave resident alone. [Resident #2] approached [Resident #6] again and was seen criss [sic] crossing the strings on a neck pillow that was on the residents neck and was stopped by kitchen staff and reported it appropriately. [Name withheld] PD [police department] contacted and out to make a report and [report number withheld]. DHS [Department of Human Services] LTC [long term care] notified and APS [Adult Protective Services], DON [director of nursing], ADM [administrator], Dr. [doctor] [name withheld] and contacted family [name withheld]. One on one at all times since incident and until [they] leave the facility, pending admission acceptance to a behavioral health center. An annual resident assessment, dated 06/16/25, showed Resident #3's cognition was intact (BIMS 13). The assessment showed Resident #3 had diagnosis which included non-Alzheimer's dementia. Resident #3's care plan, revised 07/08/25, did not show behaviors or interventions had been added to the care plan. On 7/15/25 at 12:42 p.m., MDS coordinator stated the care plan was not updated with new interventions after the incident. They stated care plans were to be updated with any MDS changes, hospital stays, and any changes in health.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the physician of signs and/or symptoms of a potential infection at a urinary catheter's entry site for 1 (#2) of 2 residents sampled for indwelling urinary catheters. The administrator identified one resident with an indwelling urinary catheter. Findings: An undated policy titled Communication of Resident Condition and Treatment with Antimicrobial Orders, read in part, When facility staff suspects a resident has an infection, the nurse should appropriately document a comprehensive assessment of the resident using established and accepted assessment protocols. This assessment will determine if the resident's status meets minimum criteria for initiating antibiotics. When contacting a physician to communicate to discuss a resident's change in condition and a suspected infection, a nurse should have the medical record available and should communicate the following: written results of the written resident assessment, signs and symptoms, and time symptoms first observed. An undated medical diagnosis list showed Res #2 had diagnoses which included retention of urine and congenital bladder neck obstruction. A physician order, dated 08/07/24, showed to monitor Res #2's catheter's insertion site for signs and/or symptoms of infection and report to the physician if present. A quarterly assessment, dated 08/21/24, showed Res #2 had a BIMS score of 12 and their cognition was moderately impaired. The assessment showed Res #2 had an indwelling urinary catheter. A physician order, dated 09/03/24, showed Res #2 was scheduled for suprapubic catheter placement on 09/11/24. A nurse note, dated 09/05/24 at 7:44 p.m., showed odorous brownish drainage was observed on the penile area during catheter care. A nurse note, dated 09/07/24 dated at 10:19 a.m., showed brown drainage was observed during catheter care. A nurse note, dated 09/08/24 at 10:36 a.m., showed tannish brown drainage was observed coming from the urethra during catheter care. A nurse note, dated 09/08/24 at 7:18 p.m., showed brown drainage continued from the urethra during catheter care. A nurse note, dated 09/10/24 at 7:32 p.m., showed the resident was scheduled to have a suprapubic catheter placed at the hospital on [DATE] at 8:00 a.m. A nurse note, dated 09/11/24 at 2:28 p.m., showed Res #2 had been admitted to the hospital for a urinary tract infection and hypotension. The note showed the suprapubic catheter procedure was not performed. A hospital physician report, dated 09/11/24 at 4:04 p.m., showed Res #2 was admitted to the medical surgical floor for treatment of a complicated urinary tract infection with antibiotics. A nurse note, dated 09/12/24 at 6:46 p.m., showed Res #2 returned to the facility from the hospital. The note showed the suprapubic catheter had not been placed. On 07/15/25 at 2:47 p.m., RN #1 stated it was the nurse's responsibility to monitor catheter insertion sites for signs and/or symptoms of infection such as redness, irritation, and drainage. They stated if any signs and/or symptoms of infection were observed the physician should have been notified. On 07/15/25 at 4:00 p.m., RN #2 stated Res #2 had a history of recurrent urinary tract infections and discharge from the catheter entry site. They stated Res #2 had not been feverish or complained of pain. RN #2 stated they could not remember if the physician had been notified of the brown discharge at the catheter entry site. They denied documentation of the physician having been notified or their response. On 07/16/25 at 8:00 a.m., the infection preventionist stated the physician should have been notified after the staff observed discharge with odor from Res #2's penile area. They stated the discharge could have been an indication of an infection.</p> | | |