

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 12/31/2025
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the state agency within the 2-hour required time frame for 1 (#25) of 3 sampled residents reviewed for abuse. The administrator identified 37 residents resided in the facility. Findings: An undated facility policy titled Abuse Prohibition, read in part, the facility shall report all alleged violations and all substantial incidents to the state agency. An admission assessment, dated 12/21/24, showed Resident #25 had diagnoses which included unspecified dementia with behavioral disturbances, hyperlipidemia, anxiety disorder, and migraines. An allegation of abuse, reported to the facility administrator on 12/17/25, showed a facility staff member was observed to be rough while assisting Res #25 to a chair and spoke loudly to the resident. This allegation of abuse was not reported to the OSDH. On 12/31/25 at 12:10 p.m., the administrator stated the abuse allegation incident was reported to them and it was immediately investigated, including camera review by the cooperate office. The administrator stated they did not feel it was a reportable incident after the investigation and did not submit an incident report.</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.

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a physician's order was followed for 1 (#42) of 1 sampled resident reviewed for respiratory care. The administrator identified one resident used a BIPAP machine. Findings: On 12/29/25 at 2:53 p.m., Res #42 was observed resting in bed, stated they were taking a nap. Res #42's BIPAP machine was not turned on, and the mask was sitting on the resident's bedside table. On 12/30/25 at 2:04 p.m., Res #42 was observed resting in bed with their eyes closed. Res #42's BIPAP machine was not turned on. The mask was observed sitting on the resident's bedside table. On 12/31/25 at 8:52 a.m., Res #42 was observed resting in bed with their eyes closed. Res #42's BIPAP machine was not turned on. The mask was observed sitting on the bedside resident's bedside table. A physician order, dated 07/14/25, showed BIPAP oxygen at 3 LPM at HS and while taking naps. On 12/31/25 at 2:21 p.m., RN #1 stated the resident should have had the BIPAP on during naps.</p>