STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375384	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Hope Retirement & Care Center	1220 East Electric Blvd McAlester, OK 74501

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure assessments were accurate for anticoagulation therapy for 1 (#25) of 4 sampled residents reviewed for resident assessments.The administrator identified 37 residents resided in the facility. Findings:A quarterly assessment, dated11/05/25, showed Resident #25 received anticoagulant therapy.Resident #25's medication administration record, dated November 2025, did not show an anticoagulant medication.On 12/31/25 at 12:42 p.m., the minimum data set coordinator stated Resident #25 did not take an anticoagulant medication. They stated the assessment was coded in error and would be modified.

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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, 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.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and interview, the facility failed to ensure the removal of expired medications and supplies from 1 of 1 medication rooms observed.The administrator reported 37 residents resided in the facility.Findings: On 12/31/25 at 1:15 p.m., the medication storage room was observed with RN #1. The following medications/supplies were observed to be expired:One box of 25-gauge needles with 3 ml syringe with an expiration date of 08/31/25,One box of 21-gauge needles with 3 ml syringe with an expiration date of 12/02/25,Four packets of Dyna Lube (a lubricating jelly) with an expiration date of 03/20/20,Eight tubes of lubricating jelly with an expiration date of 11/24/22,Eleven bisacodyl suppositories with an expiration date of 08/05/25,Six bisacodyl suppositories with an expiration date of 03/24/25.On 12/31/25 at 1:30 p.m., RN #1 stated the expired medications and supplies should have already been removed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on record review and interview, the facility failed to ensure dietary staff received training in safe food handling practices for the prevention of foodborne illness for 2 (Cook #3 and Dietary Aide #3) of 7 dietary staff reviewed for staff training. The administrator identified 37 residents received meals from the dietary department. Findings:On 12/22/25 at 11:10 a.m., the dietary manager was asked for verification of food handlers training for all dietary staff.On 12/30/25 at 3:00 p.m., the administrator submitted copies of food handlers training certificates for five of the seven dietary staff. The administrator stated cook #1 and dietary aide #3 had not received the required training.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview, the facility failed to follow the menu for 1 of 1 meal services observed.The administrator identified 37 residents received nutrition from the kitchen.Findings:On 12/22/25 at 12:30 p.m., chicken fried steak, mashed potatoes and gravy, cream corn, dinner roll and pineapple crisp was observed to be served for the noon meal. The menu for week five showed crumb crusted chicken, savory rice, Brussel sprouts, dinner roll and pineapple crisp.An undated policy titled, Menu Substitution, read in part, menu substitutions will be recorded on a substitution record form. The reason for the change will also be noted. On 12/22/25 at 12:30 p.m., the dietary manager stated they were working off of the week five menu this week and had to substitute items due to not having the menu items available. The dietary manager stated they did not document substitutions or specific reasons for substitutions and did not have a form that they were aware of.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure:a. prepared food items were labelled with the preparation and use-by dates,b. food items were discarded after the expiration dates,c. temperature logs were accurate and completed for refrigerators and freezers,d. food temperatures were checked and logged for prepared food items, e. food was prepared in a sanitary environment, andf. food was not stored on the floor in dry storage area. The administrator identified 37 residents received nutrition from the kitchen. Findings:On 12/22/25 at 9:48 a.m., the following observations were made in the double door refrigerator in the kitchen:a. a container of prepared coleslaw with a manufacturer use by date of 12/13/25. b. a container of cottage cheese with a manufacturer use by date of 11/15/25. c. two plastic pitchers with lids with juice type liquid contents without label, preparation or use by datesOn 12/22/25 at 9:59 a.m., a log sheet titled Daily Refrigerator and Freezer Temperature Log, dated December 2025, was reviewed. There was no documentation of temperatures for December 22 and December 23. On 12/22/25 at 10:20 a.m., six chest type freezers with frozen food items were observed. There were not visible thermometers inside.On 12/22/25 at 10:30 a.m., the food preparation area between stove, steam table and counters was observed to have missing floor tiles. The floor in the dry food storge area was observed to have rough surfaces with debris and buildup of a dark matter.On 12/22/25 at 10:32 a.m., two cardboard boxes of apple juice drink blend were observed stored on the floor of the dry storage room under shelving.On 12/23/25 at 11:30 a.m., cook #1 was observed to prepare food for lunch service without checking temperatures of the prepared foods. A facility policy titled Sanitation and Infection Control, dated 2005, read in part, refrigerate food in small, shallow, covered, dated and labelled containers.A facility policy titled Food Cookery, dated 2005, read in part, use a meat thermometer to check internal temperatures.On 12/23/25 at 11:30 a.m., cook #1 stated they did not know they were supposed to check the temperatures of food when it was finished cooking.On 12/23/25 at 11:35 a.m., the dietary manager stated they did not have a process in place or a log for food that was cooked and served. On 12/23/25 at 12:00 p.m., the dietary manager stated they knew food items in the refrigerator were supposed to be labeled and dated and expired food items have been discarded. The dietary manager stated thermometers had been ordered for the freezers and the staff had not been checking them since there were not any thermometers in the freezers. The dietary manager stated the floors had been a problem for several months and were scheduled to be repaired. The dietary manager stated they had been very difficult to clean with the missing tiles and rough floor surface.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review and interview, the facility failed to ensure the water management plan to prevent waterborne pathogens had the participation of the infection preventionist. The administrator identified 37 residents resided in the facility.Findings:A facility policy titled Legionella Water Management Program, dated 1/2022, read in part, As part of the infection prevention control program, our facility has a water management program, which is overseen by the water management team. The document also showed:a. there was a water management team consisting of the infection preventionist, the administrator, the medical director or their designee, the director of maintenance, and the director of environmental services,b. a detailed description and diagram of the water system in the facility, including receiving, cold water distribution, heating, hot water distribution and waste, andc. the identification of areas in the water system that could encourage growth and spread waterborne bacteria.A facility cleaning schedule attached to the Legionella water management program for 2025, showed shower heads and quarterly cleaning schedule completed for January, April and July 2025. There was no documentation located for the month of October 2025.On 12/30/25 at 2:24 p.m., the infection preventionist stated they did not know they were on the water management team.On 12/30/25 at 2:24 p.m. the administrator stated they did not have a diagram for a water management program and there was no documentation for the month of October 2025 in the logbook.