STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375386	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quail Ridge Living Center, Inc	564 State Line Road Colcord, OK 74338

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to:a. ensure residents did not fall during a transfer for 1 (#84) of 2 sampled residents reviewed for accident hazards; b. ensure safety interventions were in place while smoking for 1 (#6) of 2 sampled residents reviewed for accident hazards; andc. ensure the electrical room door was secured for 1 of 1 electrical room observed.The DON identified 29 residents required two person assistance with transfer, 18 residents smoked, and 85 residents resided in the facility. Findings: 1. A policy titled Safe Lifting and Movement of Residents, dated 07/2017, read in part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. A care plan for Resident #84, revised 10/27/23, showed they required extensive assistance of two staff members to transfer between surfaces. A quarterly assessment for Resident #84, dated 01/03/25, showed the resident had a brief interview for mental status score of 15, which indicated intact cognition for daily decision making. The assessment showed Resident #84 required maximal assistance from staff during chair to bed transfers. An incident report, dated 02/17/25, showed on 02/03/25 at approximately 10:00 p.m., CNA #1 was transferring Resident #84 without the assistance of another staff member. The report showed Resident #84 was assisted to the floor and an x-ray was obtained on 02/04/25 that did not show any injuries. On 07/02/26 at 9:45 a.m., Resident #84 stated CNA #1 was transferring them from the chair to the bed without any assistance. Resident #84 stated once they were on the side of the bed, they lost their balance and CNA #1 assisted them to the floor. On 07/02/26 at 11:25 a.m., CNA #2 stated the care plan should always be followed while transferring residents. On 07/02/26 at 11:35 a.m., CNA #3 stated they would refer to the care plan or ask the nurse if they didn't know how much assistance a resident required. On 07/02/26 at 11:40 a.m., the DON stated, at the time of the incident, Resident #84 required two-person assistance with transfers and CNA #1 had not transferred Resident #84 appropriately. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 07/02/2026 at 9:20 a.m., Resident #6 was observed smoking in the designated smoking area without a smoking apron. Facility staff were observed supervising the smoking area. On 07/02/2026 at 9:23 a.m., CNA #3 was observed to enter the smoking area and assisted Resident #6 with putting on a smoking apron. On 07/02/26 at 9:42 a.m., no cigarette burn holes were observed on the clothes Resident #6 was wearing or any of the clothes in their closet. A policy titled Smoking Policy – Residents, dated 10/2023, read in part, This facility has established and maintains safe resident smoking practices. An unsigned smoking assessment for Resident #6, dated 04/19/26, showed the resident required a fire-resistant smoking apron and supervision while smoking. A care plan for Resident #6, dated 05/18/26, showed the resident required supervision, a smoking apron, and would be safe at all times while smoking. On 07/02/26 at 9:22 a.m., LPN #1 stated they did not normally supervise smoke breaks. LPN #1 stated they did not know which residents required a smoking apron. On 07/02/2026 at 9:23 a.m., CNA #3 stated a list of residents and their required safety needs was on the inside of the smoker box lid. On 07/02/2026 at 9:38 a.m., Resident #6 stated they have had no burns while smoking and had no burns on their clothing. On 07/02/26 at 10:36 a.m., the DON stated Resident #6 was required to wear a smoking apron and to be supervised by staff while smoking based on a smoking assessment completed 04/19/26 by LPN #2. The DON stated Resident #6 utilized a smoking apron as a precaution, due to being unsteady. The DON stated a list of residents that smoked and their safety needs was kept in box that contained smoking supplies. The DON stated staff were educated on smoking safety during orientation and in-services. 3. On 06/29/26 at 10:54 a.m., a door labeled Electrical Room was observed to have a locking door handle. The electrical room was observed on E hall, next door to the DON's office and in view of the nurses' desk. The DON was observed to open the door to the electrical room without a key. Items observed in the electrical room included paint, power tools, insect spray on shelves, electrical cords, and enabler bars on the floor. The DON was observed to lock the door to the electrical room. No residents were observed attempting to access the electrical room during this time. On 06/29/26 at 10:54 a.m., the DON stated the door labeled Electrical Room located on E Hall should have been locked. The DON stated the electrical room had paint, power tools, insect spray, electrical cords, enabler bars, and other items on shelves in reach of residents if the unlocked door was accessed. The DON stated the maintenance supervisor had been working on a doorknob on an adjacent door and was running an errand at that time. On 06/29/26 at 11:28 a.m., the maintenance supervisor stated the electrical room door on E Hall was kept locked most of the time and they had just been in and out of it several times this morning. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintenance supervisor stated they had accessed the electrical room approximately 20 minutes prior to the door being found unlocked.

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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 the ice machine was maintained in a sanitary manner. The administrator identified 85 residents received nourishment from the kitchen. Findings: On 06/29/26 at 10:03 a.m., the ice machine was observed to have a black slimy substance on the underside of the plastic rim inside the ice compartment. A maintenance log titled Monthly Deep Cleaning Schedule 2026 was reviewed. The log showed the ice machine had been cleaned in March 2026, April 2026, and May 2026. On 06/29/26 at 10:15 a.m., the dietary manager stated the black substance on the ice machine appeared to be grime and it should not have been in the ice machine. They stated the ice machine was due for a weekly cleaning.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to ensure residents were free from physical abuse for 1 (#76) of 1 sampled resident reviewed for abuse.The DON stated 85 residents resided in the facility.Findings:A document titled ABUSE, NEGLECT AND MISAPPROPRIATION or RESIDENT'S FUND, dated 03/18/15, read in part, The resident has the right to be free from verbal, sexual, physical, mental, corporal punishment, and involuntary seclusion. The document had been signed by CNA #8.A policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021, read in part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.A document titled ABUSE, NEGLECT AND MISAPPROPRIATION or RESIDENT'S FUND, dated 06/10/24, read in part, The resident has the right to be free from verbal, sexual, physical, mental, corporal punishment, and involuntary seclusion. The document had been signed by CNA #4.A written statement from Resident #76, dated 03/10/26, read in part, [Name withheld], my night shift C.N.A. and her helpmate, about 3 days ago, slid me up on my bed, raming [sic] my head in the head board [sic]! I hollered out in pain! But it didn't make any difference to them. Two days later I told them they hurt me, being so rough!.A written statement Resident #89, dated 03/11/2026, showed the resident stated having been in the room and heard when Resident #76's head was bumped against the headboard by the CNAs. An email statement from CNA #8, dated 3/11/2026, read in part, Last week I'm not sure the day, [CNA #4] and I changed [Resident #76] on E Hall and afterwards pulled [them] up in the bed. [Their] head bumped the headboard. It wasn't hard but we did bump it. [Resident #76] said ow and I apologized immediately and asked if [they] were okay. [Resident #76] stated [they] were fine. I rubbed [their] head to feel if there was a bump and asked several times if [they] were okay or if it hurt and each time, [they] said no. Both [CNA #4] and I apologized for using too much strength to pull [them] up.An incident report, dated 03/12/26, showed on 03/11/26 around 9:00 p.m., Resident #76 reported to facility staff on 03/08/26, two CNAs were moving them up in the bed and CNA #8 pulled them up and they hit their head on the headboard.A document titled Mandatory Reporting Protocol, dated 03/12/26, showed staff education was completed over the requirements for staff reporting allegations of abuse.An employee counseling record, dated 03/13/26, showed CNA #4 was terminated for failure to report an allegation of abuse.An employee termination record, dated 03/13/26, showed CNA #4, was not recommended for re-employment at the facility due to an allegation of abuse.An employee counseling record, dated 03/13/26, showed CNA #8, was terminated for failure to report an allegation of abuse.An employee termination record, dated 03/13/26, showed CNA #8, was not recommended for re-employment at the facility due to an allegation of abuse. A document titled In-Service Sign In, dated 03/20/26, showed topics discussed during training included abuse, neglect, exploitation and reporting to the abuse coordinator.On 6/30/26 at 3:26 p.m., Resident #76 stated, I had two on the night shift that were rough with me and hit my head on the headboard when I was moved up in the bed. Resident #76 stated they did not remember the CNAs names who had provided the care.On 07/01/26 at 11:51 a.m., the DON stated Resident #76 reported their head was bumped into the headboard of their bed on 03/08/26 while care was being provided by CNA #8 and CNA #4. The DON stated Resident #76 said they reported their head was bumped into the headboard because their neck continued to hurt 03/11/26 after the incident. The DON stated during the investigation, Resident #57 stated CNA #4 and CNA #8 had provided rough care when assisting them.On 07/01/26 at 11:55 a.m., the administrator stated abuse allegations and failure to report abuse for CNA #4 and CNA #8 were substantiated after the facility investigation was completed due to Resident #76's head having been hit into the headboard on 03/08/26. The administrator stated Resident #76 never reports anything about staff for abuse. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administrator stated CNA #8 had worked at the facility for several years with no complaints concerning care provided.On 07/01/26 at 12:09 p.m., Resident #57 stated they did not recall reporting any abuse by facility staff, but they had been repositioned roughly by two CNAs a while back. Resident #57 stated they didn't remember the names of the staff that provided the care. Resident #57 stated the staff had worked on the night shift and They were gone now and I'm glad. Resident #57 stated, They were just rough with me.

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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 physical abuse was reported for 1 (#76) of 1 sampled resident reviewed for abuse.The DON reported 85 residents resided in the facility.Findings:A policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021, read in part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.A written statement from Resident #76, dated 03/10/26, read in part, [Name withheld], my night shift C.N.A. and her helpmate, about 3 days ago, slid me up on my bed, raming [sic] my head in the head board [sic]! I hollered out in pain! But it didn't make any difference to them. Two days later I told them they hurt me, being so rough!.An email statement from CNA #8, dated 3/11/2026, read in part, Last week I'm not sure the day, [CNA #4] and I changed [Resident #76] on E Hall and afterwards pulled [them] up in the bed. [Their] head bumped the headboard. It wasn't hard but we did bump it. [Resident #76] said ow and I apologized immediately and asked if [they] were okay. [Resident #76] stated [they] were fine. I rubbed [their] head to feel if there was a bump and asked several times if [they] was okay or if it hurt and each time [they] said no. Both [CNA #4] and I apologized for using too much strength to pull [them] up.An employee counseling record, dated 03/13/26, showed CNA #4 was terminated for failure to report an allegation of abuse.An employee counseling record, dated 03/13/26, showed CNA #8, was terminated for failure to report an allegation of abuse.A document titled In-Service Sign In, dated 03/20/26, showed topics discussed during training included abuse, neglect, exploitation, and reporting to the abuse coordinator.On 07/01/26 at 11:55 a.m., the administrator stated abuse allegations and failure to report abuse were substantiated after the facility investigation for CNA #4 and CNA #8 due to Resident #76's head having been hit into headboard on 03/08/26. The administrator stated They should have reported each other. If one thought the other was being rough then the other should have reported or when the resident said they hurt them, they should have reported it immediately.

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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 observation, record review, and interview, the facility failed to ensure urinary catheter bags were not on the floor for 1 (#41) of 5 sampled residents reviewed for urinary catheters. The DON identified five residents with urinary catheters. Findings: On 06/29/26 at 10:30 a.m., Resident #41's urinary catheter bag was observed on the floor at the bedside, On 06/30/26 at 2:00 p.m., Resident #41's urinary catheter bag was observed on the floor at the bedside. An undated policy titled Catheter Care, Urinary, read in part, 2. Be sure the catheter tubing and drainage bag are kept off the floor. On 07/01/26 at 1:30 p.m., CNA #11 stated urinary catheter bags should be in a dignity bag, hung on the bed frame, and not on the floor. On 07/01/26 at 1:40 p.m., CNA #2 stated a urinary catheter bag should be hung on the bed frame and not in contact with the floor. On 07/01/26 at 2:03 p.m., CNA #9 stated urinary catheter bags should be hung on the side of the bed and not on the floor. On 07/01/26 at 2:07 p.m., CNA #10 stated a urinary catheter bag should not be on the floor. On 07/01/26 at 2:15 p.m., LPN 1 stated urinary catheter bags should be hung on the side of the bed and not on the floor. They stated if a urinary catheter bag was on the floor, it could cause the resident to develop a urinary tract infection. On 07/01/26 at 2:20 p.m., the DON stated urinary catheter bags should be hung on the bed frame and should not touch the floor. They stated if a catheter bag touched the floor, it could result in a urinary tract infection.