STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375451	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Health Care Center	1120 Illinois Street Muskogee, OK 74403

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure a fall intervention to toilet a resident every hour was implemented for 1 (Resident #85) of 3 sampled residents reviewed for falls.Findings included: An admission Record indicated the facility admitted Resident #85 on 04/16/2026. According to the admission Record, the resident had a medical history that included a diagnosis of heart failure. Resident #85's Baseline Care Plan, with an admission date of 04/16/2026, indicated the resident required one person physical assistance for toilet use, was always incontinent of urinary continence, frequently incontinent of bowel continence, and had a history of falls. Resident #85's incident report dated 04/16/2026, indicated the resident was on the floor in front of their wheelchair in front of the nurses' station due to an attempt to stand. Per the incident report, the resident slipped, fell, and landed on their buttocks in front of their wheelchair. The incident report indicated the resident had no apparent injuries and stated they needed to go to the bathroom. According to the incident report, after the fall the facility implemented an intervention to toilet the resident every hour. Resident #85's medication administration record (MAR) and treatment administration record (TAR) for the timeframe 04/01/2026 - 04/30/2026 revealed no documented evidence Resident #85 was checked for toilet use every hour. Resident #85's Task List Report revealed no indication certified nursing assistant (CNA) staff checked the resident for toilet use every hour. During an interview on 06/10/2026 at 9:20 AM, Licensed Practical Nurse (LPN) #3 stated all of their residents were checked for incontinence every two hours. LPN #3 stated after Resident #85's fall on 04/16/2026, the resident was to be checked for toileting every hour. LPN #3 stated sometimes every one-hour toileting would be listed on the TAR or the MAR. During an interview on 06/10/2026 at 1:56 PM, LPN #8 stated when a resident was on an every one-hour toileting check it would be documented in the CNA tasks, MAR, or TAR. According to the LPN #8, staff toileted Resident #85 every two hours. During an interview on 06/10/2026 at 2:50 PM, the Director of Nursing (DON) stated the intervention implemented after Resident #85 fell on [DATE] was to toilet the resident every hour. The DON stated that whenever an intervention of every-hour toileting was implemented, the process was to place an order for CNAs on their task sheet. The DON reviewed the task orders for the CNA staff and stated there was not an every-hour toileting order. The DON stated the order could show up on the MAR, TAR, or the task sheet for the CNAs. The DON stated that would be how the CNA staff and nursing staff knew to implement the intervention. The DON acknowledged the intervention to toilet Resident #85 every hour was not implemented. During an interview on 06/11/2026 at 8:25 AM, the Administrator stated fall interventions should be implemented immediately.

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, record review, document review, and facility policy review, the facility failed to ensure a licensed practical nurse (LPN) knew how to prime an insulin pen for 1 (Resident #7) of 6 residents observed for medication administration.Findings included: An undated facility document titled, Job description for Charge Nurse, specified Job Knowledge: 1. Knowledge of procedures and techniques necessary to administer medications and treatment as prescribed by the physician. An undated facility document titled, Staff education Policy signed by the Director of Nursing (DON), indicated It is the policy of this facility to perform Staff education or in-services based on the required annual in-services by the state and any additional training that is needed by the staff on an as need basis. An admission Record revealed the facility admitted Resident #76 on 11/16/2020. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2026, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #76's Care Plan Report included a focus area revised 06/11/2024, that indicated the resident was at risk for complications related to diabetes mellitus. Interventions directed staff to administer Lantus (insulin) as physician ordered (revised 11/07/2024). Resident #76's Order Summary Report with active orders as of 06/11/2026, revealed an order dated 11/06/2024, for Lantus subcutaneous solution inject 40 units subcutaneously one time a day related to type 2 diabetes mellitus. During medication administration observation on 06/10/2026 at 7:22 AM, LPN #2 did not prime the Lantus insulin pen before she injected 40 units of Lantus insulin into Resident #76's right lower abdominal quadrant. During an interview on 06/10/2026 at 11:49 AM, LPN #2 stated she had no knowledge of how to prime an insulin pen and was not sure how or why the process would be completed. LPN #2 stated if priming was needed, she should have primed the pen before she administered Lantus to Resident #76 on 06/10/2026. LPN #2's LPN/LVN [licensed vocational nurse] Knowledge & Skills Checklist dated 10/06/2025, revealed no evidence of training on how to prime an insulin pen. During an interview on 06/11/2026 at 9:28 AM, the Medical Director stated insulin pens should be primed before administration to get the air out of the needle. During an interview on 06/11/2026 at 10:33 AM, the DON stated she would expect all nurses administering insulin by way of an insulin pen to receive training on insulin administration. During an interview on 06/11/2026 at 11:05 AM, the Administrator stated she deferred her expectation of competency of nurses to prime an insulin pen to the DON.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, facility policy review, and the manufacturer's guidelines, the facility failed to ensure the medication error rate was 5 percent (%) or less. The facility had 3 medication errors out of 34 opportunities, which yielded a medication error rate of 8.82% for 2 (Resident #76 and Resident #7) of 6 residents observed for medication administration. Findings included: A facility policy titled, Medication Administration, revised 06/03/2025, revealed, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy specified, 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 1. The manufacturer's guidelines for the Lantus pen, with a copyright date of 2022, indicated, Step 3. Perform a safety test * Dial a test dose of 2 units * Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. * Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. * If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. An admission Record revealed the facility admitted Resident #76 on 11/16/2020. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2026, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #76's Care Plan Report included a focus area revised 06/11/2024 that indicated the resident was at risk for complications related to diabetes mellitus. Interventions directed staff to administer Lantus (insulin) as physician ordered (revised 11/07/2024). Resident #76's Order Summary Report with active orders as of 06/11/2026, revealed an order dated 11/06/2024, for Lantus subcutaneous solution, inject 40 units subcutaneously one time a day related to type 2 diabetes mellitus. During medication administration observation on 06/10/2026 at 7:22 AM, Licensed Practical Nurse (LPN) #2 did not prime the Lantus insulin pen before she injected 40 units of Lantus insulin into Resident #76's right lower abdominal quadrant. During an interview on 06/10/2026 at 11:49 AM, LPN #2 stated she had no knowledge of how to prime an insulin pen and was not sure how or why the process would be completed. LPN #2 stated that if priming was needed, she should have primed the pen before she administered Lantus to Resident #76 on 06/10/2026. During an interview on 06/10/2026 at 12:13 PM, the Director of Nursing (DON) stated she deferred her expectation of priming an insulin pen prior to administration to the Assistant Director of Nursing (ADON). During an interview on 06/10/2026 at 12:19 PM, the ADON stated she expected a nurse to dial the insulin pen to 2-3 units to prime the pen, then push the plunger to get the air out of the line before dialing the ordered dose of insulin to be administered to the resident. The ADON stated priming the insulin pen prior to administration was important to ensure the air bubbles were out and to ensure the resident received the correct dose of insulin. The ADON stated LPN #2 should have primed the insulin pen prior to administration of insulin to Resident #76. During an interview on 06/11/2026 at 9:28 AM, the Medical Director stated insulin pens should be primed before administration to get the air out of the needle. During an interview on 06/11/2026 at 11:05 AM, the Administrator stated she deferred her expectation of priming an insulin pen to the DON. 2. An admission Record revealed the facility admitted Resident #7 on 12/15/2022. According to the admission Record, the resident had a medical history that included diagnoses of essential hypertension and atrial fibrillation. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/06/2026, revealed Resident #7 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making. Resident #7's Care Plan Report, included a focus area (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 08/14/2022 that indicated the resident had an altered cardiovascular system related to hypertension and hyperlipidemia (high cholesterol). Interventions directed staff to administer amiodarone and diltiazem as the physician ordered. Resident #7's medication administration record (MAR) for the timeframe 06/01/2026 - 06/30/2026, revealed the transcription of an order dated 11/04/2025, for amiodarone hydrochloride (HCL) oral tablet 200 milligrams (mg), give one tablet by way of the percutaneous endoscopic gastrostomy (PEG) tube one time a day related to atrial fibrillation and hold for a systolic blood pressure less than 120 millimeters of mercury (mmHg) or a heart rate less than 60 beats per minute (bpm). The MAR also revealed the transcription of an order dated 11/03/2025, for diltiazem HCL tablet 30 mg, give one table by way of PEG tube two times a day related to hypertension and hold for a systolic blood pressure less than 120 mmHg or a heart rate less than 60 bpm. During medication administration observation on 06/10/2026 at 8:29 AM, Certified Medication Aide (CMA) #10 prepped and administered one tablet of amiodarone HCL 200 mg when Resident #7 had a heart rate of 62 bpm and one tablet of diltiazem HCL 30 mg when the resident had a systolic blood pressure of 101 mmHg. During an interview on 06/10/2026 at 8:56 AM, CMA #10 stated Resident #7 had a systolic blood pressure of 101 mmHg and a pulse (heart rate) of 62 bpm. CMA #10 stated she had been taught to read the resident's physician's orders for hold parameters, but she did not notice the parameters before she administered amiodarone and diltiazem to Resident #7 by way of the resident's PEG tube. CMA #10 stated she should have held the two medications because the resident's blood pressure was outside of the set parameters. During an interview on 06/10/2026 at 10:09 AM, Licensed Practical Nurse (LPN) #3 stated she oversaw CMA #10. LPN #3 stated she had not been made aware that CMA #10 administered Resident #7's medications when the resident's blood pressure was outside the hold parameters. LPN #3 stated t the two medications for the resident's blood pressure with hold parameters should have been held if the resident's blood pressure was 101/61 mmHg. During an interview on 06/11/2026 at 9:28 AM, the Medical Director (MD) stated he was notified Resident #7 was administered amiodarone and diltiazem by CMA #10 when the resident's vital signs were outside the hold parameters. The MD stated that although the medications should have been held, he did not think the medications would pose a significant concern to the resident. During an interview on 06/11/2026 at 10:33 AM, the Director of Nursing (DON) stated CMA #10 should have read the entire order and administered medications according to the physician's orders. The DON stated CMA #10 should have held (not administered) the cardiac (heart) medication. During an interview on 06/11/2026 at 11:05 AM, the Administrator stated she expected staff to read and follow the physician's orders.

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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, interview, record review, and facility policy review, the facility failed to ensure a resident's supplemental oxygen tubing was stored in a plastic bag when not in use for 1 (Resident #41) of 1 sampled resident reviewed for respiratory care.Findings included: A facility policy titled, Oxygen Administration, revised 06/03/2025, indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The policy specified, e. Keep delivery devices covered in plastic bag when not in use. An admission Record indicated the facility admitted Resident #41 on 10/02/2023. According to the admission Record, the resident had a medical history that included a diagnosis of acute respiratory failure with hypoxia. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/03/2026, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #41's Care Plan Report included a focus area initiated 03/12/2026, that indicated the resident was at risk for altered respiratory status related to acute respiratory failure with hypoxia. Interventions specified the administration of supplemental oxygen at 2 liters per minute (L/M) by way of nasal canula (NC) per concentrator for shortness of breath (SOB) to maintain the resident's oxygen saturation greater than 90%. Resident #41's Order Summary Report with active orders as of 06/10/2026, revealed an order dated 04/28/2026, for supplemental oxygen at 2 L/M by way of NC per concentrator as needed for SOB to maintain the resident's oxygen saturation level greater than 90%. During an observation on 06/08/2026 at 10:28 AM, 06/09/2026 at 3:54 PM, and 06/10/2026 at 9:47 AM, Resident #41's supplemental oxygen tubing was observed on the floor under the oxygen concentrator in the resident's room. During a concurrent interview and observation on 06/09/2026 at 11:14 AM, Resident #41 they used the supplemental oxygen at night when needed. The surveyor noted Resident #41's supplemental oxygen tubing was on the floor. Resident #41 stated the supplemental oxygen tubing was on the floor, and they were not aware of how the tubing got on the floor as they did not take off the tubing. Resident #41 stated the staff took off their supplemental oxygen and placed the tubing somewhere. During an interview on 06/10/2026 at 3:11 PM, the Director of Nursing stated she expected supplemental oxygen tubing to be stored in a zip lock bag. During an interview on 06/11/2026 at 8:25 AM, the Administrator stated supplemental oxygen tubing should be appropriately stored inside a bag.