STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375463	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pauls Valley Care Center	1413 South Chickasaw Street Pauls Valley, OK 73075

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was not involuntarily discharged during hospitalization for 1 (#40) of 3 sampled residents reviewed for discharge.The DON identified 36 residents resided in the facility. Findings:An undated facility Bed-Holds and Returns policy read in part, If a Medicaid resident exceeds the state bed-hold period, he or she will be permitted to return to the facility .provided that the resident .a. Requires services of the facility; and b. Is eligible for Medicare skilled nursing services or Medicaid nursing services .If the resident is transferred with the expectation that he or she will return, but it is determined that the resident cannot return or the resident exceeds the 30 days out of facility as noted in the facility that resident will be formally discharged . In event that occurs resident will have to request admission through the facility referral/admission process. The resident will be permitted to return to an available bed in the location of the facility that he or she previously resided.An undated admission RECORD showed Resident #40 received long term care services and their primary payer was Medicaid.A discharge return anticipated resident assessment, dated 09/30/25, showed Resident #40 had an unplanned discharge to a short-term general hospital stay on 09/30/25. The assessment showed the resident had diagnoses which included recurrent unspecified major depressive disorder and anxiety. The assessment showed Resident #40's memory was OK and was independent in cognitive skills for daily decision making.A nursing note, dated 09/30/25, showed Resident #40 was vomiting and chilled and requested to go to the hospital. An order was received to transfer the resident with emergency medical services.A hospital Discharge summary, dated [DATE], showed the hospital sent the facility a referral on 10/30/25. The discharge summary showed the facility informed the hospital the resident was discharged from their facility. The discharge summary showed Resident #40 had completed their intravenous antibiotics on 11/01/25 and was ready for discharge to the facility on [DATE]. The discharge summary showed the facility involuntarily discharged the resident without a 30-day notice. The discharge summary showed the resident wanted to be transferred back to the facility and had reached out to the ombudsman for legal assistance.On 12/17/25 at 1:34 p.m., the DON stated the resident was transferred to the hospital on [DATE].On 12/17/25 at 1:35 p.m., the administrator stated Resident #40 was discharged from the facility on 10/31/25 because they were out of the facility for 30 days per facility policy.On 12/17/25 at 1:40 p.m., the DON stated the hospital reached out to the facility regarding the resident's return. They stated the resident was on an intravenous antibiotic infusion and required labs to monitor the trough and peak. They stated the facility did not have the ability to complete the required labs.On 12/17/25 at 1:44 p.m., the DON stated the hospital suggested for the resident to return to the facility after completion of the antibiotics. The DON stated they the informed the hospital the resident would be evaluated upon completion of the antibiotics.On 12/17/25 at 1:50 p.m., the administrator stated Resident #40 was not allowed to return to the facility after completion of the intravenous antibiotics.On 12/17/25 at 1:52 p.m., the administrator stated the hospital had sent a referral to the facility for Resident #40's return.On 12/17/25 at 1:54 p.m., the administrator stated they did not allow the resident to return to the facility based on their prior (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history. The administrator stated they felt like they could not meet Resident #40's needs.On 12/17/25 at 1:55 p.m., the administrator stated the facility could not meet the resident's psychosocial needs. They stated Resident #40 shared with them they had sued the facility previously and the facility filed bankruptcy and there was no money for the resident. The administrator stated the resident took that out on them and had not been able to make the resident happy. They stated the resident prided themselves on being mean to the staff.On 12/17/25 at 2:11 p.m., the administrator stated they had residents with similar needs as Resident #40. They stated those residents were compliant with behavioral services.On 12/17/25 at 3:30 p.m., the DON stated they could not locate documentation to show they had attempted to secure alternate placement for the resident.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a:a. bed hold policy upon transfer;b. discharge notice to the resident and/or representative; andc. copy of the discharge notice to the ombudsman for 1 (#40) of 3 sampled residents reviewed for discharge.The DON identified 36 residents resided in the facility. Findings: An undated facility policy Bed-Holds and Returns, read in part, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Resident #40's discharge return anticipated resident assessment, dated 09/30/25, showed the resident had an unplanned discharge to a short-term general hospital stay on 09/30/25. The assessment showed the resident had diagnoses which included recurrent unspecified major depressive disorder and anxiety. The assessment showed Resident #40's memory was OK and was independent in cognitive skills for daily decision making. A nursing note, dated 09/30/25, showed Resident #40 was vomiting and chilled and requested to go to the hospital. An order was received to transfer the resident with emergency medical services. There was no documentation a bed-hold policy was provided to the resident. On 12/17/25 at 1:34 p.m., the DON stated the resident was transferred to the hospital on [DATE]. On 12/17/25 at 1:35 p.m., the administrator stated Resident #40 did not receive a bed-hold policy. They stated Resident #40 was discharged from the facility on 10/31/25 because they were out of the facility for 30 days per facility policy. On 12/17/25 at 1:50 p.m., the administrator was asked if a discharge notice was provided to the resident. They stated they provided residents with a bed-hold policy. On 12/17/25 at 3:37 p.m., the administrator stated they did not get an opportunity to provide the ombudsman with a discharge notice because Resident #40 had reached out to the ombudsman and the ombudsman contacted the facility. They stated their process was to mail out discharge notices to the ombudsman. On 12/18/25 at 3:39 p.m., the ombudsman stated they were not provided with a discharge notice for Resident #40.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure comprehensive assessments were completed within 14 days for 1 (#3) of 12 sampled residents reviewed for comprehensive assessments.The DON identified 36 residents resided in the facility.Findings:An undated diagnoses report showed Resident #3 was admitted on [DATE].An annual assessment for Resident #3 showed an assessment reference date of 06/25/25. MDS Coordinator #1 and the DON signed the assessment as completed on 08/05/25.On 12/18/25 at 3:37 p.m. MDS coordinator #1 stated Resident #3's annual assessment, dated 06/25/25, was not completed or transmitted until 08/05/25. They stated it was not completed or transmitted timely. They stated the assessment should have been completed by the 14th day after the assessment reference date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the initiation of a comprehensive nutrition care plan for 1 (#1) of 12 sampled residents reviewed for care plans.The DON identified 36 residents resided in the facility.Findings:An undated admission record for Resident #1 showed the resident admitted to the facility on [DATE] with diagnoses which included chronic kidney disease and diabetes mellitus.A care plan for Resident #1, initiated on 07/16/25, did not show Resident #1 had a nutritional care plan.On 12/16/25 at 1:04 p.m., MDS coordinator #1 stated care plans were to be completed within 21 days of admission and updated quarterly.On 12/16/25 at 1:05 p.m., MDS coordinator #1 stated care plans were updated with different things, falls, when resident has changes. They stated it was a bit complicated to keep up with both care plans and MDS assessments, but it was more complicated to keep up with care plans.On 12/16/25 at 1:10 p.m., MDS coordinator #1stated they did not see a nutritional care plan for Resident #1.