

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Ada Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 931 North Country Club Road Ada, OK 74820	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure 1) food was labeled with the open date and the expiration date for 1 of 2 kitchen observations and 2) expired foods were discarded for 1 of 2 refrigerators. The failure had the likelihood to affect the 38 residents in the facility. Findings included: A facility policy titled, Food Safety Requirements, revised on 06/30/2025, indicated, Food safety practices shall be followed throughout the facility's entire food handling process. Practices to maintain safe refrigerated storage include labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or discarded. A facility policy titled, Date Marking for Food Safety, revised on 06/30/2025, indicated, The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. 1. During an initial kitchen observation on 06/01/2026 at 9:15 AM, five large plastic containers of cereal with closed lids were on the serving line to be used in pouring up individual servings into bowls during the meal service. The five plastic cereal containers were labeled raisin bran, fruit loops, rice krispies, corn flakes, and bran. The cereal containers were three-fourths full, except for the container labeled bran, which was one-fourth full. The five plastic cereal containers were not dated as to when the cereal was opened or with an expiration date. During an interview on 06/01/2026 at 9:20 AM, the Dietary Supervisor (DS) stated the original cereal packages were opened and the contents were placed in the plastic containers to make it easier for the cereals to be poured on the service line by the Cook. The Dietary Supervisor confirmed the plastic cereal containers lacked the date each cereal was opened and the date each cereal expired. The DS stated she expected the kitchen staff to label all foods with open and expired dates. During an interview on 06/04/2026 at 3:44 PM, the Administrator stated she expected all food items to be labeled correctly with the date the item was opened and when it expired. 2. During the initial kitchen observation on 06/01/2026 at 9:30 AM, Refrigerator #1 had four 5-pound containers of low-fat cottage cheese that were beyond their expiration dates. One container had expired on 01/06/2026, and three containers had expired on 05/13/2026. During an interview on 06/01/2026 at 9:35 AM, the Dietary Supervisor (DS) confirmed the four containers of low-fat cottage cheese in the refrigerator had expired and should have been used prior to the expiration date or discarded on the expiration date. The DS stated the cooks were supposed to review food containers for expiration dates. The DS stated the containers should have been thrown away. The DS stated the food could have been spoiled and had bacterial growth that could make residents sick if served to them. The DS stated she expected the kitchen staff to monitor all foods for use-by or expired dates and to remove items from the kitchen that were expired. During an interview on 06/04/2026 at 3:44 (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure:- staff performed hand hygiene between handling soiled and clean items during wound care/dressing changes for 2 (Resident #20 and Resident #44) of 2 residents observed for dressing changes/wound care;- staff performed hand hygiene between providing direct care to 2 (Resident #28 and Resident #24) of 5 sampled residents observed for hand hygiene during care;- staff donned appropriate personal protective equipment (PPE) during care of residents who required enhanced barrier precautions (EBP) for 2 (Resident #34 and Resident #28) of 5 sampled residents reviewed for EBP.- staff performed hand hygiene between residents during food and beverage services for residents who resided on 1 (East Hall) of 3 halls; and,- the laundry area was clean and free of excessive dust and dryer lint, dirty laundry containers were covered, and clean and dirty laundry was separated in 1 of 1 laundry room. This failure had the potential to affect all 40 residents who resided in the facility. Findings included: A facility policy titled, Hand Hygiene, revised 04/10/2025, indicated, All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The policy further indicated, 7. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. A facility policy titled, Infection Prevention and Control Program, revised 04/02/2025, indicated, 4b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. C. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. A facility policy titled, Enhanced Barrier Precautions, revised 04/10/2025, indicated, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The policy also specified, 4. High-contact resident care activities include: a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC [peripherally inserted central catheter] lines, midline catheters. h. Wound care: any skin opening requiring a dressing. 1. An admission Record revealed the facility admitted Resident #20 on 07/25/2025. According to the admission Record, the resident had a medical history that included diagnoses of basal cell carcinoma of the skin and restless leg syndrome. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2026, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had five venous and/or arterial ulcers and required the application of nonsurgical dressings and ointments/medications to areas other than the feet. Resident #20's Care Plan included a focus area revised on 06/01/2026 that indicated the resident had impairment to skin integrity related to basal cell carcinoma, cellulitis, and fungal infections. Interventions directed staff to refer to on-site wound care for evaluation and treatment as indicated (initiated 07/29/2025) and referral to vascular doctor related to slow healing vascular wounds (initiated on 07/25/2025). Resident #20's Treatment Administration Record for June 2026 indicated the resident was to receive scheduled and as-needed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(PRN) skin/wound care as follows:- Dakins (a sodium hypochlorite-based topical antiseptic) 1/4-strength external solution 0.125% - apply to right/left (RT/LT) lower leg and right and left (R&L) foot topically every day shift every Monday, Wednesday and Friday for wound care. Refer to Silvadene order.- MediHoney wound/burn dressing external gel - apply to left lateral lower leg topically as needed for wound care. Start date: 06/01/2026.- Silvadene external cream 1% - apply to right lower leg (RLL), left anterior lower leg ([NAME]), left foot (LF), right foot (RF) topically as needed for wound care. Start date: 06/01/2026. During an observation on 06/02/2026 at 10:18 AM, Licensed Vocational Nurse (LVN) #9 gathered supplies to perform Resident #20's wound care and donned a gown and gloves without first performing hand hygiene. LVN #9 cleaned the resident's bilateral legs with gauze pads moistened with H-Chlor (a sodium hypochlorite-based topical antiseptic) 0.125%, then removed her gloves and donned clean gloves without performing hand hygiene. The LVN used betadine swab sticks then applied Medihoney gel and Silvadene cream to the resident's bilateral legs, then removed her gloves and applied clean gloves without first performing hand hygiene. During an interview on 06/02/2026 at 3:40 PM, LVN #9 stated that she changed gloves between cleaning and applying the different creams. She stated that she was not aware of a need to perform hand hygiene between glove changes and indicated she was not supposed to leave the room during wound care and that no chemicals were allowed in the resident's room. LVN #9 stated she had not been trained and/or expected to do hand hygiene between glove changes. During an interview on 06/04/2026 at 11:47 AM, the Director of Nursing (DON) stated that infection prevention was reviewed at every facility in-service twice a month. She stated that she observed staff to ensure they were doing the right thing. During a follow-up interview at 1:43 PM, the DON stated that she had conducted in-services on handwashing by watching the staff to catch them in real time and re-educate them. During an interview on 06/04/2026 at 3:19 PM, the Administrator stated that staff had been trained and were expected to perform hand hygiene before putting on or taking off gloves and during medication pass. During a follow-up interview at 3:30 PM, the Administrator stated that she monitored the staff for infection control but had nothing written down. She stated there was a performance improvement plan (PIP) related to hand hygiene that started in April for the facility. Review of a document titled, Proper Hand washing Procedures with Return Demonstration, dated 9/25 (it was unclear whether this represented September 25th of an unknown year or September 2025), indicated LVN #9 was observed performing a return demonstration of hand hygiene. LVN #9's signature on the document was also dated 9/25. The document indicated, 2. Appropriate ten second hand washing must be performed under the following conditions: The list of conditions included the following:- e. Before handling clean or soiled dressings, gauze pads, etc. [et cetera].- f. After handling used dressings, contaminated equipment, etc.- j. After removing gloves. The document also indicated, 3. The use of gloves does not replace hand washing. 2. An admission Record revealed the facility admitted Resident #34 on 03/31/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic kidney disease and benign prostatic hyperplasia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/14/2026, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had an indwelling catheter Resident #34's Care Plan included a focus area initiated 03/27/2024 that indicated the resident had an indwelling urinary catheter and required assistance with toileting hygiene. Interventions directed staff to use enhanced barrier precautions (EBP) as indicated and to wear at least gloves/gowns when performing high contact resident care activities such as providing hygiene, changing briefs, or performing device care including urinary catheter care (revised 04/07/2026). During an observation on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	before and after serving each resident but that she should have done so. She stated she was aware that she should wash her hands before and after serving each resident. CMA #7 stated she did not like the hand sanitizer gel that was provided by the facility. She stated she had hand hygiene training about a month ago and that hand hygiene was important because, you can carry germs from one person to the other. During an interview on 06/02/2026 at 3:00 PM, CNA #8 stated she should have used hand sanitizer after coming out of a resident's room before entering the next room. She stated that she had been working at the facility for over a year and that she had received in-service training on hand hygiene a little while ago, during which she was required to perform a return demonstration. She stated that after using hand sanitizer three times, she should be washing her hands with soap and water. CNA #8 stated she did not remember receiving education on when to perform hand hygiene during meal pass. She stated that she was just in a rush and forgot to perform hand hygiene because this was her first time performing meal service. During an interview on 06/04/2026 at 11:35 AM, the Minimum Data Set/ Licensed Vocational Nurse (MDS/LVN) stated that she, along with the Director of Nursing (DON), provided in-services at every staff meeting and as issues arose regarding infection control and hand hygiene. She stated that every payday they took the opportunity to conduct in-services. During an interview on 06/04/2026 at 11:47 AM, the DON stated the facility went over infection control information at every in-service twice per month. She stated that during some months, they went more in-depth. The DON stated the facility held people accountable and would [NAME] on staff about infection control but could not babysit them. She stated that she also observed staff without their knowledge to ensure they were doing the right thing. The DON stated there was no official training on meal pass but that the staff received on-the-job training with the person they were shadowing. During a follow-up interview on 06/04/2026 at 3:22 PM, the DON stated that it was her expectation that staff use hand sanitizer and then wash with soap and water after every third use of hand sanitizer. She stated for some tasks, staff may need to wash their hands more often. She indicated hand hygiene was, one of our biggest training topics that we hit the most. During an interview on 06/04/2026 at 3:51 PM, the Administrator stated it was her expectation that staff use hand sanitizer before they picked up meal trays, between trays, and after meal pass. She stated the facility had a hand hygiene skills check-off during their most recent in-service.		

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NAME OF PROVIDER OR SUPPLIER Ada Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 931 North Country Club Road Ada, OK 74820	
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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Citation Form for QAFacility: Ada Care CenterSurveyor: [NAME] 51215Tag: F655S/S: EList other surveyors citing this tag: [NAME] and [NAME] AgarwalWho is writing the deficient practice statement? [NAME] Based on interview, record review, and facility policy review, the facility failed to initiate baseline care plans within 48 hours for 4 of 7 residents (Residents #4, #25, #28, and #44). Findings included: The facility's policy titled, Baseline Care Plan, revised on 06/30/2025, indicated, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. A supervising nurse shall verify withing 48 hours that a baseline care plan has been developed. 1. Resident #25's admission Record indicated the facility admitted the resident on 04/30/2026. According to the admission Record, the resident had a medical history that included diagnoses (DX) of chronic obstructive pulmonary disease, schizophrenia, major depressive disorder, anxiety disorder, nuclear cataract, bilateral primary open-angle glaucoma, and convulsions. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2026, revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A review of Resident #25's medical record revealed no baseline care plan, and the resident's comprehensive care plan was initiated on 05/06/2026, seven days after their admission to the facility on [DATE]. During an interview on 06/02/2026 at 1:36 PM, the MDS/Licensed Vocational Nurse (LVN) revealed that the facility did not have separate baseline care plans for residents, and that a resident's comprehensive care plan was initiated on admission and updated throughout their stay and when changes occurred. During a follow up interview on 06/04/2026 at 11:02 AM, the MDS/LVN stated she made sure care plans were opened and submitted in a timely manner. 2. Resident #28's admission Record indicated the facility admitted the resident on 04/29/2026. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus with diabetic neuropathy, parkinsonism, multiple sclerosis, paroxysmal atrial fibrillation, acute diastolic (congestive) heart failure, chronic obstructive pulmonary disease, and end stage renal disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/12/2026, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15. Review of Resident #28's medical record revealed no baseline care plan, and the resident's comprehensive care plan was initiated on 05/05/2026, six days after their admission to the facility on [DATE]. During an interview on 06/02/2026 at 1:36 PM, the MDS/Licensed Vocational Nurse (LVN) revealed that the facility did not have separate baseline care plans for residents, and that a resident's comprehensive care plan was initiated on admission and updated throughout their stay and when changes occurred. During a follow up interview on 06/04/2026 at 11:02 AM, the MDS/LVN stated she made sure care plans were opened and submitted in a timely manner. 3. An admission Record revealed the facility admitted Resident #4 on 05/01/2026. According to the admission Record, the resident had a medical history that included nondisplaced comminuted fracture of the right fibula. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2026, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Review of Resident #4's medical record revealed no baseline care plan, and the resident's comprehensive care plan was initiated on 05/06/2026, seven days after their admission to the facility on [DATE]. During an interview on 06/02/2026 at 1:36 PM, (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the MDS/Licensed Vocational Nurse (LVN) revealed that the facility did not have separate baseline care plans for residents, and that a resident's comprehensive care plan was initiated on admission and updated throughout their stay and when changes occurred. During a follow up interview on 06/04/2026 at 11:02 AM, the MDS/LVN stated she made sure care plans were opened and submitted in a timely manner. MDS/LVN stated that she was not sure of the time frame to create the baseline care plan but that she tries to get them in as soon as possible. 4. An admission Record revealed the facility admitted Resident #44 on 05/28/2026. According to the admission Record, the resident had a medical history that included diagnoses of acute respiratory failure, bipolar disorder, autistic disorder, and ileus. A Minimum Data Set (MDS), dated [DATE], was completed for the resident, with no Brief Interview for Mental Status (BIMS) completed. Review of Resident #44's medical record revealed no baseline care plan, and the resident's comprehensive care plan was initiated on 06/01/2026, three days after their admission to the facility on [DATE]. During an interview on 06/02/2026 at 1:36 PM, the MDS/Licensed Vocational Nurse (LVN) revealed that the facility did not have separate baseline care plans for residents, and that a resident's comprehensive care plan was initiated on admission and updated throughout their stay and when changes occurred. During a follow up interview on 06/04/2026 at 11:02 AM, the MDS/LVN stated she made sure care plans were opened and submitted in a timely manner. MDS/LVN stated that she was not sure of the time frame to create the baseline care plan but that she tries to get them in as soon as possible. During an interview on 06/04/2026 at 3:27 PM, the Director of Nursing (DON) stated that it was her expectation that the care plan be completed in a timely manner. The DON stated she thought the timeframe for the baseline care plan to be initiated was 24 hours but was not sure. During an interview on 06/04/2026 at 3:51 PM, the Administrator stated that she was not clinical and therefore would defer to her nursing team for MDS and care plans, but it was her expectation that baseline care plans be completed in a timely manner.		

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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 observation, interview, record review, facility policy review, and review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure the most recent resident assessment accurately reflected a resident's smoking status, which affected 1 (Resident #28) of 3 residents reviewed for accident hazards related to smoking. Findings included: The Centers for Medicare & Medicaid Services [CMS] Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2025, revealed, J1300: Current Tobacco Use included Steps for Assessment, which included 1. Ask the resident if they used tobacco in any form during the 7-day look-back period; 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes; and 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the lookback period, review the medical record and interview staff for any indication of tobacco use by the resident during the lookback period. The manual revealed, Coding Instructions, which revealed, Code 0, no: if there are no indications that the resident used any form of tobacco; and Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. An admission Record indicated the facility admitted Resident #28 on 04/29/2026. According to the admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD). An admission Admission/Re-admission/Quarterly/Significant Change Assessment, dated 04/29/2026 and completed by Licensed Vocational Nurse (LVN) #3, indicated that the resident smoked, used electronic cigarettes, or used tobacco products at the time of the assessment. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/12/2026, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed that J1300 was coded to indicate that the resident did not use tobacco at the time of the assessment. Resident #28's Care Plan Report included a focus area initiated 05/05/2026, that indicated that the resident had an activity of daily living self-care performance deficit. The Care Plan Report did not include any information related to the resident smoking. During an observation on 06/01/2026 at 11:35 AM, Resident #28 was observed outside smoking during a scheduled smoking time. During an interview on 06/02/2026 at 11:58 AM, Resident #28 revealed that they usually kept smoking material on their person or in the nightstand drawer. Resident #28 stated that a smoking assessment was completed upon admission and that staff were aware of their smoking habits. During an interview on 06/03/2026 at 3:36 PM, LVN #3 stated that Resident #28 told him that they were an unsupervised smoker at the time of admission. He stated that the Director of Nursing (DON), the Assistant Director of Nursing (ADON)/MDS/LVN, and all the other nurses could see what was documented in the admission records that he completed. During an interview on 06/03/2026 at 9:15 AM, the DON revealed that she and the ADON/MDS/LVN completed the MDS assessments and adjusted the care plans as things came up or if there was a need to update them. During an interview on 06/04/2026 at 11:02 AM, the ADON/MDS/LVN stated that she was aware that Resident #28 smoked and confirmed that she did not reflect that on the resident's MDS. She stated that she was responsible for completing the MDS assessments, but they were signed off by the DON before they were closed and submitted. ADON/MDS/LVN stated that she looked at a lot of information, like the nursing documentation, medication administration records (MARS), treatment administration records (TARs), behavior notes, and certified nursing assistant (CNA) documentation, to complete the MDS. She stated that depending on which section of the MDS she is looking at determined which documents she looks at. The ADON/MDS/LVN stated that at the beginning of the (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, she completed a resident interview where she reviewed documentation and asked the resident if they would like to continue smoking. MDS/LVN stated that she was responsible for completing the MDS, creating the care plans, adding diagnoses and medications, and based on conversation with the resident, anything else necessary. During an interview on 06/04/2026 at 3:27 PM, the DON revealed that she tried to assist with admissions along with the ADON/MDS/LVN. The DON stated that it was her expectation that the MDS assessments be accurate. She stated that smoking should have been indicated on Resident #28's MDS. During an interview on 06/04/2026 at 3:51 PM, the Administrator revealed that she was not clinical staff and therefore deferred to her nursing team for MDS related questions.		

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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. Based on facility policy review, record review, observation, and interview, the facility failed to ensure a resident's comprehensive person-centered care plan accurately reflected the resident's status for 1 of (Resident #10) of 2 residents reviewed for respiratory care and 2 (Resident #25 and Resident #28) of 3 residents reviewed for accident hazards related to smoking. Findings included: A facility policy titled, Comprehensive Care Plans, revised 06/30/2025, indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 1. A facility policy titled, Oxygen Administration, revised 05/16/2025, indicated, 1. Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and resident's goals and preferences. The policy revealed, 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to, which included a, The type of oxygen delivery system; b. When to administer, such as continuous or intermittent and/or when to discontinued; and c. Equipment setting for prescribed flow rates. An admission Record revealed the facility admitted Resident #10 on 02/19/2026. According to the admission Record, the resident had a medical history that included a diagnosis of obstructive sleep apnea. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2026, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #10 had an active diagnosis of obstructive sleep apnea. The MDS indicated that the resident received respiratory treatments via a non-invasive mechanical ventilator. Resident #10's Order Summary Report, with active orders as of 06/02/2026, contained an order, dated 02/27/2026, to ensure that a CPAP was on at bedtime related to obstructive sleep apnea, and to remove the CPAP every morning. The report did not include specific orders for the settings of the CPAP machine. Resident #10's Care Plan Report included a focus area initiated 02/20/2026, that indicated the resident was at risk for altered respiratory status related to obstructive sleep apnea. The Care Plan Report did not include any information about Resident #10's use of a CPAP machine. During a concurrent observation and interview on 06/01/2026 at 11:31 AM, a CPAP mask was on top of Resident #10's bed. Resident #10 stated that they (Resident #10) did everything needed for the CPAP, including cleaning the mask, and they knew the CPAP order. During an observation on 06/01/2026 at 2:00 PM, a CPAP machine was observed next to the resident's bed in an open dresser drawer. During a concurrent observation and interview on 06/02/2026 at 3:06 PM, Resident #10 was lying on their bed and holding the CPAP mask to their face. Resident #10 stated that they were preparing to take a nap. The resident also stated that they managed the CPAP machine themselves by turning the CPAP machine on and off. An observation on 06/04/2026 at 9:37 AM revealed Resident #10 was lying in bed sleeping with their CPAP mask on. During an interview on 06/03/2026 at 11:05 AM, Licensed Vocational Nurse (LVN) #2 stated that if a resident used a CPAP, it should have been documented on the resident's care plan. During an interview on 06/04/2026 at 11:47 AM, the Assistant Director of Nursing (ADON)/MDS/LVN stated that she was aware that Resident #10 had a CPAP machine. She stated that a care plan should be in place for the CPAP for Resident #10, but there had been no MDS triggers for it to put it in the resident's care plan. 2. A facility policy titled, Resident Smoking, revised 06/10/2025, indicated It is (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. The Policy Explanation and Compliance Guidelines revealed 5. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS [Minimum Data Set] assessment process. The policy revealed 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. An admission Record indicated the facility admitted Resident #25 on 04/30/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD); schizophrenia unspecified; major depressive disorder recurrent, moderate; anxiety disorder, unspecified; age-related nuclear cataract of the left eye; ocular hypertension, bilateral (higher than normal pressure inside both eyes); primary open-angle glaucoma, bilateral, stage unspecified; and unspecified convulsions. An admission MDS, with an Assessment Reference Date (ARD) of 05/07/2026, revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that Resident #25 was a current tobacco user at the time of the assessment. Resident #25's Care Plan Report included a focus area initiated 05/06/2026, that indicated the resident had an activity of daily living (ADL) self-care performance deficit. Interventions directed staff to provide assistance with one to two staff members with all ADLs. The Care Plan Report did not include a focus area, goals, or interventions related to smoking. During an observation and interview on 06/02/2026 at 3:25 PM, Resident #25 was lying on their bed in their room. A lighter was on top of the nightstand. Resident #25 stated it was usually kept there or in their pants pocket for smoke break. Resident #25 stated they attended the smoke break that morning and had been doing so since admission when staff assisted. Resident #25 stated they had received the facility rules about smoking at the time of admission and kept their cigarettes on them. Resident #25 opened their nightstand drawer, revealing a carton of cigarettes. Resident #25 stated that staff were always present during the smoke break. During an interview on 06/04/2026 at 11:02 AM, the Assistant Director of Nursing (ADON)/MDS/Licensed Vocational Nurse (LVN) stated that she was aware that Resident #25 was a smoker and admitted to not completing a care plan reflecting it. She stated that she would be adding it. An admission Record indicated the facility admitted Resident #28 on 04/29/2026. According to the admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD). An admission Admission/Re-admission/Quarterly/Significant Change Assessment, dated 04/29/2026 and completed by LVN #3, indicated that the resident smoked, used electronic cigarettes, or used tobacco products at the time of the assessment. An admission MDS, with an ARD of 05/12/2026, revealed Resident #28 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #28's Care Plan Report included a focus area initiated 05/05/2026, that indicated that the resident had an activity of daily living self-care performance deficit. The Care Plan Report did not include any information related to the resident smoking. During an observation on 06/01/2026 at 11:35 AM, Resident #28 was observed outside smoking during a scheduled smoking time. During an interview on 06/02/2026 at 11:58 AM, Resident #28 revealed that they usually kept smoking material on their person or in the nightstand drawer. Resident #28 stated that a smoking assessment was completed upon admission and that staff were aware of their smoking habits. During an interview on 06/03/2026 at 3:36 PM, LVN #3 stated that Resident #28 told him that they were an unsupervised smoker at the time of admission. He stated that the Director of Nursing (DON), the ADON/MDS/LVN, and all the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other nurses could see what was documented in the admission records that he completed. During an interview on 06/03/2026 at 9:15 AM, the DON revealed that she and the ADON/MDS/LVN completed the MDS assessments and adjusted the care plans as things came up or if there was a need to update them. During an interview on 06/04/2026 at 3:27 PM, the DON stated that smoking should be reflected on a resident's care plan.		

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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. Based on facility policy review, record review, observation, and interview, the facility failed to accurately complete a smoking safety assessment to determine the potential hazards or risks for 1 (Resident #25) of 3 residents reviewed for accident hazards related to smoking. Findings included: A facility policy titled, Resident Smoking, revised 06/10/2025, indicated It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. The Policy Explanation and Compliance Guidelines revealed 5. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS [Minimum Data Set] assessment process. The policy revealed 6. Residents who smoke will be further assessed to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. The policy revealed 8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. The policy revealed 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. The policy revealed 15. Documentation to support decision making will be included in the medical record, may include but not limited to, which included a. Resident's wishes, or those of the resident's representative; b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely; c. Response to smoking cessation interventions; and Compliance with smoking policy. An admission Record indicated the facility admitted Resident #25 on 04/30/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD); schizophrenia unspecified; major depressive disorder recurrent, moderate; anxiety disorder, unspecified; age-related nuclear cataract of the left eye; ocular hypertension, bilateral (higher than normal pressure inside both eyes); primary open-angle glaucoma, bilateral, stage unspecified; and unspecified convulsions. An admission MDS, with an Assessment Reference Date (ARD) of 05/07/2026, revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed that Resident #25 required supervision or touch assistance with all activities of daily living (ADLs). The MDS indicated that Resident #25 was a current tobacco user at the time of the assessment. Resident #25's Care Plan Report included a focus area initiated 05/06/2026, that indicated the resident had an ADL self-care performance deficit. Interventions directed staff to provide assistance with one to two staff members with all ADLs. The Care Plan Report did not include a focus area, goals, or interventions related to smoking. Resident #25 admission Progress Notes, dated 04/30/2026, written at 5:01 PM, revealed no documentation of his smoking preferences, nor any smoking discussion or assessment. An Admission/Re-Admission/Quarterly/Significant Change Assessment, dated 04/30/2026, included a Safe Smoking Evaluation that indicated that Resident #25 did not currently smoke. The assessment did not include the name of the person who completed it. During an observation and interview on 06/02/2026 at 3:25 PM, Resident #25 was lying on their bed in their room. A lighter was on top of the nightstand. Resident #25 stated it was usually kept there or in their pants pocket for smoke break. Resident #25 stated they attended the smoke break that morning and had been doing so since admission when staff assisted. Resident #25 stated they had received the facility rules about smoking at the time of admission and kept their cigarettes on them. Resident #25 opened their (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nightstand drawer, revealing a carton of cigarettes. Resident #25 stated that staff were always present during the smoke break. An observation on 06/03/2026 at 8:46 AM revealed Resident #25 outside, in the smoking area. Resident #25 was smoking alongside five other residents, and Certified Nursing Assistant (CNA) #1. During an interview on 06/03/2026 at 9:00 AM CNA #1 stated that education was provided on orientation about smoke breaks and taking residents out. CNA #1 stated that staff were aware of which residents should be supervised; their cigarettes were kept in the locked box labeled with their names. During an interview on 06/04/2026 at 8:41 AM Licensed Vocational Nurse (LVN) #2 stated that the facility had an admission packet that was completed when an admission arrived at the facility. LVN #2 stated that they also received a report from the hospital, and they discussed preferences like if the resident was a smoker and how often they smoked during the head-to-toe assessment. She stated that then all retrieved information was typed in a nurse note, then added to the admission form in the packet. LVN #2 stated that the assessment sheet in the admission packet then went to the Director of Nursing (DON) for further addition and completion. LVN #2 stated that Resident #25 revealed being a smoker but did not have any supplies at the time of admission. LVN #2 stated that it was in error that the assessment documentation reflected that the resident was not a smoker. LVN #2 stated that she did not realize that an error was made. During an interview on 06/03/2026 at 9:15 AM the DON stated that there was no one person responsible for the smoking task. The DON stated that the nurses were responsible for completing the smoking assessment and scheduling someone to accompany the residents on the smoke breaks. The DON further stated that ultimately, the responsibility lay with herself and the Assistant Director of Nursing (ADON)/MDS/LVN, to complete the MDS and assessments, adjust the care plans as needed, or update them when necessary. During an interview on 06/04/2026 at 11:39 AM the ADON/MDS/LVN revealed that there was an admission assessment completed that covered all the assessment areas so staff did not miss anything, however, Resident #25's admission assessment was only checked to ensure completion, not for errors. During an interview on 06/04/2026 at 3:27 PM the DON stated that both herself and the ADON/MDS/LVN tried to assist with admissions, but the charge nurse was supposed to do it for the most part. The DON stated that the expectation was for the admission assessment to be completed in a timely manner. During an interview on 06/04/2026 at 3:51 PM the Administrator stated that the expectation was for assessments, including MDS assessments, and care plans to be completed in a timely manner but noted that nursing questions would be referred to the clinical team. The Administrator stated that they reviewed the new admissions charts the following morning for additional information on residents' needs and preferences.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Ada Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 931 North Country Club Road Ada, OK 74820	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on facility policy review, record review, observation, and interview, the facility failed to ensure physician orders for the use and care of a continuous positive airway pressure (CPAP) machine included ordered settings, which affected 1 (Resident #10) of 2 residents reviewed for respiratory care. Findings included: A facility policy titled, Oxygen Administration, revised 05/16/2025, indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and resident's goals and preferences. The Policy Explanation and Compliance Guidelines revealed, 1. Oxygen is administered under orders of a physician, except in the case of an emergency. The policy revealed, Types of delivery systems include which included d. CPAP Mask-this mask is part of a system that allows a resident to receive continuous positive airway pressure (CPAP), with or without an artificial airway. The system is comprised of a mask, tubing, and a machine that generates a constant flow of air pressure. Machines have different settings. The policy revealed, 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to, which included a, The type of oxygen delivery system; b. When to administer, such as continuous or intermittent and/or when to discontinued; and c. Equipment setting for prescribed flow rates. An admission Record revealed the facility admitted Resident #10 on 02/19/2026. According to the admission Record, the resident had a medical history that included a diagnosis of obstructive sleep apnea. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2026, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #10 had an active diagnosis of obstructive sleep apnea. The MDS indicated that the resident received respiratory treatments via a non-invasive mechanical ventilator. Resident #10's Care Plan Report included a focus area initiated 02/20/2026, that indicated the resident was at risk for altered respiratory status related to obstructive sleep apnea. The Care Plan Report did not include any information about Resident #10's use of a CPAP machine. Resident #10's Order Summary Report, with active orders as of 06/02/2026, contained an order, dated 02/27/2026, to ensure that a CPAP was on at bedtime related to obstructive sleep apnea, and to remove the CPAP every morning. The report did not include specific orders for the settings of the CPAP machine. During a concurrent observation and interview on 06/01/2026 at 11:31 AM, a CPAP mask was on top of Resident #10's bed. Resident #10 stated that they (Resident #10) did everything needed for the CPAP, including cleaning the mask, and they knew the CPAP order. During an observation on 06/01/2026 at 2:00 PM, a CPAP machine was observed next to the resident's bed in an open dresser drawer. During a concurrent observation and interview on 06/02/2026 at 3:06 PM, Resident #10 was lying on their bed and holding the CPAP mask to their face. Resident #10 stated that they were preparing to take a nap. The resident also stated that they managed the CPAP machine themselves by turning the CPAP machine on and off. An observation on 06/04/2026 at 9:37 AM revealed Resident #10 was lying in bed sleeping with their CPAP mask on. During an interview on 06/03/2026 at 11:05 AM, Licensed Vocational Nurse (LVN) #2 stated that residents who used a CPAP machine should have two physician orders, one that specified the CPAP schedule and one that directed the treatment nurse to monitor its use. LVN #2 reviewed Resident #10's physician orders and confirmed that the medical record did not contain a physician order for the CPAP settings. During an interview on 06/03/2026 at 4:12 PM, LVN #3 stated that when a resident had a CPAP machine, the LVN ensured the machine had distilled water, confirmed the machine was clean, and verified the physician orders. LVN #3 stated that to his knowledge, he had not ever seen (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders specifically for the CPAP settings. During an interview on 06/05/2026 at 10:16 AM, the Administrator stated she expected medical staff to have all appropriate orders in place for resident care.		