STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375486	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Health Care	1307 R D Miller Drive Okmulgee, OK 74447

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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 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 facility policy review, facility document review, observation, and interview, the facility failed to ensure food was labeled appropriately and failed to ensure leftovers were discarded according to the facility's procedures. The failures had the potential to affect all of the residents who received nourishment from the kitchen.Findings included: A facility policy titled, Food Storage, revised 02/06/2024, indicated, Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. The policy revealed, 2. Refrigerator, which included, All foods are covered, labeled and dated. A facility policy titled, Nutrition/Dietary Services, revised 01/16/2025, indicated, The staff will utilize the Nutrition Services Guidelines and standard practice guidelines. The policy revealed the Procedure included C. Food must be obtained from sources that comply with all laws relating to food and food labeling. If food, subject to spoilage, is removed from its original container, it must be kept sealed, and labeled. Food subject to spoilage must also be dated. A facility document titled, Nutrition Services Manual, approved by the facility 01/23/2025, included a Sample Inservice Topics section, which included a document titled, Storage Times for the Refrigerator and Freezer, which revealed, These short but safe time limits for home-refrigerated foods will keep them from spoiling or becoming dangerous to eat. The document indicated that Soups & Stews with Vegetable and meat added could be in the refrigerator 3 to 4 days. 1. During an initial kitchen observation on 06/15/2026 at 8:45 AM, the following items were observed undated in the reach-in refrigerator:- One bag of sliced lunch meat (unopened)- One bag of diced chicken (opened)- One bag of shredded mild cheddar cheese (opened)- One bag of sausage patties (unopened)- One jug of barbeque sauce (opened)- One jug of chocolate syrup (opened)- One jug of ketchup (opened) During the observation on 06/15/2026 at 8:45 AM in the same reach-in refrigerator, there was a metal container covered with aluminum foil labeled as Mexican Soup, dated 06/08/2026. During an interview on 06/18/2026 at 1:41 PM, Dietary Aide (DA) #8 stated that before food was put in the refrigerator, it had to be labeled with the date it was received, and if the item was opened, the received date and the date opened also had to be labeled on the item. During an interview with the Nutritional Services Manager (NSM) and the Registered Dietician (RD) on 06/17/2026 at 3:39 PM, the NSM stated that there were signs all over the kitchen about dating food items, but she had a lot of new staff members, and she had been trying to make sure the staff were following the policies. The RD stated she had also been helping to make sure the staff were trained to date items and stayed compliant. The NSM stated that the items observed in the reach-in refrigerator without dates should have been dated and the Mexican soup should have been thrown away. The RD stated that her expectation was that items be dated and labeled when they were put in the refrigerator. The NSM stated her expectation was that all food items were to be labeled and discarded appropriately per policy. During an interview on 06/18/2026 at 9:34 AM, the Director of Nursing (DON) stated her expectation was food items to be dated and removed at the correct times. During an interview on 06/18/2026 at 9:43 AM, the Administrator stated his expectation was the food items to be all dated when the item was received and when the item was opened.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on facility policy review, facility document review, record review, observation, and interview, the facility failed to ensure a resident's right of a dignified existence for 1 (Resident #7) of 1 resident reviewed for dignity issues. Specifically, the staff failed to ensure a urinary catheter drainage bag was covered in order to protect the resident's dignity. Findings included: A facility policy titled, Resident Rights, revised 08/14/2022, indicated, The staff will abide by and protect resident rights in accordance with state and federal guidelines. An undated facility document titled, [Name of the facility] Resident & Family Handbook indicated, 6. Every resident shall receive respect and privacy in the medical care program of the resident. Case discussion, consultation, examination and treatment shall remain confidential andshall be conducted discreetly. The document further indicated, 11. Every resident shall have the right to receive courteous and respectful care and treatment and a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and a statement of related charges, including any costs for services no covered under Medicare or Medicaid, or not covered by the facility's basic per diem rate. A Record of Admission indicated the facility admitted Resident #7 on 09/12/2023. The Record of admission revealed the resident had a medical history that included a diagnosis of neuromuscular dysfunction of bladder (when an injury or disease interrupts the electrical signals between the nervous system and bladder function). A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2026, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had an indwelling catheter. Resident #7's Plan of Care-Current included a problem statement initiated 06/18/2025, that indicated the resident had an indwelling catheter. The Plan of Care-Current revealed no interventions for covering or placement of the catheter bag. Resident #7's Active Orders Report, dated 06/17/2026, contained an order, dated 05/15/2026, for an indwelling catheter and specified a continuous gravity drainage. The order indicated that the privacy bag was to be checked every shift. During a concurrent observation and interview during the initial tour of the facility an on 06/15/2026 at 10:12 AM, Resident #7's indwelling catheter drainage bag was hanging on their bed and facing the door with yellow urine inside and was visible from the hallway. Resident #7 stated it bothered them that the urine bag was exposed. Resident #7 stated staff did put the drainage bag in a privacy bag sometimes and stated that the privacy bag was at their bedside hanging on the wheelchair. During an observation on 06/16/2026 at 10:15 AM, Resident #7's room door was open, and the indwelling catheter drainage bag was visible from the hallway hanging on the bedframe. During an interview on 06/17/2026 at 3:22 PM, Licensed Practical Nurse (LPN) #7 stated it was important to use a privacy bag for the indwelling urinary collection bag for dignity purposes. LPN #7 stated Resident #7 should have had their drainage bag in a privacy bag on 06/15/2025 and 06/16/2026 when it was hanging on the bed and visible from the hallway. During an interview on 06/17/2026 at 3:40 PM, the Director of Nursing (DON) stated it was important to cover a urinary collection bag for dignity purposes. The DON stated she expected Resident #7's urinary drainage bag to be placed in a privacy bag for dignity purposes. During an interview on 06/17/2026 at 4:08 PM, the Administrator stated he would defer to the DON in regard to Resident #7's urinary drainage bag being seen from the hallway.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview, record review, and facility policy review, the facility failed to communicate with one resident prior to changing the resident's code status (designation to indicate life-saving interventions) for 1 (Resident #3) of twenty-two residents reviewed for advance directives. Specifically, the Director of Nursing (DON) changed Resident #3's code status to DNR (Do Not Resuscitate) without consulting with the resident. Findings included: A facility policy titled, Advanced Directives, revised 02/12/2022, in the section, Advanced Care Planning indicated, 1) In order for the resident to exercise his or her right to make informed choices about care and treatment in preparation for a time when the resident may not be able to make decisions, designated personnel and/or physician will assist with defining and clarifying medical issues and presenting the information regarding relevant health care issues to the resident or his/her legal representative, in a language that the resident can understand, as appropriate. A Record of Admission revealed the facility admitted Resident #3 on 02/29/2024. Resident #3's Record of admission indicated, Advanced Directives: Code Status - Full Code, DNR. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/14/2026, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #3's Plan of Care - Current included a Problems/Strengths statement, effective 10/13/2025, that indicated, Advance Directive - [Resident #3's name] has chosen to be a DNR. Interventions directed staff to:- Ensure Advanced Directives were discussed and appropriate paperwork was obtained (effective 05/01/2025);- Notify the physician and representative of any changes in the resident's condition (effective 05/01/2025);- Discuss and confirm the resident's advanced directive choices with the resident and/or responsible party or representative upon admission, quarterly, or as indicated (effective 05/01/2025);- Ensure advance [sic] directives are discussed and appropriate paperwork is provided to resident and placed in medical record (effective 05/01/2025);- Keep a copy of the MOST [Medical Orders for Scope of Treatment, a portable, physician-signed medical order] form in the medical record; and- Send a copy of the MOST form with the resident when sending out to the hospital or to other nursing facility. Resident #3's Plan of Care - Current indicated, Code Status - Full Code; DNR at the bottom of each page. Resident #3's Physician's Orders, dated from 08/01/2025 through 06/17/2026, included: Code Status - Full Code and May use AED [automated external defibrillator], ordered 12/17/2025. Resident #3's Physician's Orders revealed Advanced Directives: DNR; Code Status - Full Code at the bottom of each page. Resident #3's Physician's Telephone Order[s] included orders:- Discontinue Code Status - Full Code, and Stop date 12/17/2025 time 12:52 [PM]; and- Code Status - DNR and Start date: 06/17/[20]26 09:19 [AM].During an interview on 06/16/2026 at 2:03 PM, Resident #3 stated that at one time they did not want to be resuscitated, but now they thought they did want to be resuscitated. During an interview on 06/17/2026 at 10:43 AM, Resident #3 again stated they wanted to be resuscitated and verified they had not spoken with facility staff that morning regarding their wishes for resuscitation. During an interview on 06/17/2026 at 11:01 AM, the Director of Nursing (DON) stated that morning she entered a physician's order for Resident #3's DNR status into the electronic medical record (EMR). The DON stated the facility identified Resident #3's dual code status in the EMR, and she cleaned it up. The DON stated she did not speak with the resident prior to entering the physician's order for the DNR. During an interview on 06/18/2026 at 12:49 PM, the Administrator stated, There is zero gray area when it comes to code status. It has to be correct, and that is my expectation.

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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 develop/implement a comprehensive person-centered care plan addressing a respiratory condition or the use of a nebulizer breathing treatment for 1 (Resident #72) of 1 resident reviewed for respiratory care.Findings included: A facility policy titled, Care Plan-Process, last reviewed 03/27/2023, indicated, The interdisciplinary teal will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process within the required timeframes. The policy revealed, 4. Interdisciplinary Team meets & reviews the care plan as follows, which included With any change of condition. The policy revealed, 6. The Plan of Care identifies the, which included Problem; Goals, measurable and realistic; Interventions, discipline specific services, and frequency; and Resolution/Goal analysis. A Record of Admission revealed the facility admitted Resident #72 on 03/11/2024. According to the Record of Admission, the resident had a medical history that included diagnoses of unspecified dementia and unspecified lack of coordination. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/22/2026, revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #72's Active Orders Report, dated 06/17/2026, contained an order, dated 05/12/2026, for sodium chloride 0.9% solution (a miscellaneous respiratory agent), one vial inhalation three times a day for congestion. During an observation in Resident #72's room on 06/17/2026 at 9:31 AM, Licensed Practical Nurse (LPN) #1 added a vial of sodium chloride to a medication canister for administration of a nebulizer treatment, then applied the mask to Resident #72. Resident #72's Plan of Care-Current, dated 06/17/2026, did not include a focus area or interventions related to congestion or the use of a nebulizer. During an interview on 06/18/2026 at 12:56 PM, LPN #1 stated that she expected a resident to have a care plan for the use of a nebulizer treatment. She reviewed Resident #72's electronic medical record and stated the resident did not have a care plan for the use of a nebulizer. During a telephone interview on 06/18/2026 at 2:26 PM, the MDS Coordinator stated she had never thought of adding a care plan for nebulizer treatments. She stated she added care plans for diagnoses related to the use of a nebulizer, and the care plan would indicate administering medications per physician's orders. During an interview on 06/18/2026 at 1:30 PM, the Director of Nursing (DON) stated she expected a resident to have a care plan for the use of a nebulizer. She stated she expected the care plan to indicate the type of medication administered with the nebulizer and the reason for taking the breathing treatment. She stated that Resident #72 had an order for sodium chloride for congestion. The DON stated Resident #72 did not have a care plan that addressed congestion or the use of the nebulizer. During an interview on 06/18/2026 at 1:52 PM, the Administrator stated he expected there to be a care plan for the use of a nebulizer for breathing treatments. He stated that anything related to the resident's care required a care plan. The Administrator stated that the MDS Coordinator was responsible for care plans.

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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 observation, interview, record review, and facility policy review, the facility failed to ensure a resident in a memory care unit was supervised during a nebulizer treatment (the delivery of medication directly to the lungs) for 1 (Resident #72) of 5 residents reviewed for accidents. Findings included:A facility policy titled, Medication Administration Nebulizers, dated 01/2023, indicated, Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer.A Record of Admission revealed the facility admitted Resident #72 on 03/11/2024. According to the Record of Admission, the resident had a medical history that included diagnoses of unspecified dementia and unspecified lack of coordination. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/22/2026, revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident had severe cognitive impairment. Resident #72's Plan of Care-Current, did not include a focus area for nebulizer use or care, treatment related to a respiratory diagnosis, or the self-administration of medical treatments. Resident #72's Active Orders Report contained an order, dated 05/12/2026, for sodium chloride 0.9% solution one vial inhaled three times a day for congestion. The Active Orders Report also indicated an order to admit Resident #72 to memory care (long-term care for residents with cognitive impairment), dated 04/21/2026. The Active Orders Report did not include an order for Resident #72 to self-administer medical treatments. During an observation in the memory care unit on 06/17/2026 at 9:31 AM, Licensed Practical Nurse (LPN) #1 added a vial of sodium chloride to a medication canister for administration of a nebulizer treatment and then applied the mask to Resident #72 in the resident's room. During an observation on 06/17/2026 at 9:36 AM, LPN #1 walked out of and away from Resident #72's room during the resident's nebulizer breathing treatment. The observation revealed Resident #72 removed the mask, placed the mask on the bedside table with the medication still in the chamber, and turned off the machine.During an observation on 06/17/2026 at 9:40 AM, LPN #1 returned to Resident #72's room and reapplied the nebulizer mask to the resident. During an observation on 06/17/2026 at 9:42 AM, LPN #1 walked out of Resident #72's room during the breathing treatment. During an observation on 06/17/2026 at 9:43 AM, LPN #1 returned to Resident #72's room. During an observation on 06/17/2026 at 9:46 AM, the Assistant Director of Nursing (ADON) was at Resident #72's doorway. The observation revealed LPN #1 told the ADON that the minute LPN #1 walked out of Resident #72's room the resident took off the mask so now LPN #1 was staying with the resident. During an interview on 06/17/2026 at 9:46 AM, the ADON stated a nurse was required to stay with the resident during the breathing treatments, and LPN #1 should not have walked away in a memory care unit. The ADON stated the dangers of leaving Resident #72 unattended included the resident might not complete the treatment or another resident could grab the mask and apply it to themselves. During an interview on 06/17/2026 at 9:56 AM, LPN #1 stated Resident #72 could not self-administer medications. LPN #1 stated Resident #72 had no assessments that indicated the resident was capable of administering the breathing treatment when LPN #1 walked away. LPN #1 stated dangers of the nurse walking away during the breathing treatment included Resident #72 could have forgotten they were receiving the breathing treatment and tried to walk away while still attached to the tubing, the resident could experience side effects such as a high heart rate, or if the resident took off the mask then another resident could apply it to themselves. During an interview on 06/18/2026 at 1:29 PM, the Director of Nursing (DON) stated her expectation was that a nurse stayed with a resident during the administration of a breathing treatment. The DON stated the dangers of a nurse leaving a resident during a breathing treatment included the resident could take the treatment off, trip over the tubing, or all the medication could not be administered. During an interview on 06/18/2026 at 1:49 PM, the Administrator stated his expectation was that a nurse did not leave a resident during a breathing treatment. The Administrator stated the danger of a nurse walking away (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during the treatment was that the mask could fall off and the resident would not be getting their full treatment or another resident could put the mask on their face and use the treatment.

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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 facility policy review, manufacturer instructions review, record review, observation, and interview, the facility failed to ensure the medication administration error rate was less than 5 percent (%). The facility had 2 medication errors out of 31 opportunities, resulting in a medication error rate of 6.45%, which affected 1 (Residents #2) of 5 residents reviewed during the medication administration task.Findings included: A facility policy titled, Medication Administration General Guidelines, dated 01/2024, indicated, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. The policy further indicated, Medication Administration included 1. Medications are administered in accordance with written orders of the prescriber. A Record of Admission, indicated the facility admitted Resident #2 on 01/29/2025. According to the Record of Admission, the resident had a medical history that included a diagnosis of type 1 diabetes mellitus (the body's inability to use or make insulin properly) with hyperglycemia (high blood sugar). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/04/2026, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident received insulin injections each day during the assessment's lookback period. Resident #2's Plan of Care-Current included a problem statement initiated 09/09/2025, that indicated the resident had a diagnosis of diabetes. Interventions directed staff to administer diabetic medications as ordered (initiated 09/05/2025). Resident #2's Active Orders Report, dated 06/17/2026, contained an order, dated 03/21/2026, for Novolin R (insulin regular; a short acting insulin) FlexPen 100 units per 1 milliliter (100 U/ 1ml) solution, with instructions to inject 7 units subcutaneously every six hours. The Active Orders Report also included an order, dated 03/19/2026, for Novolog (insulin aspart; a fast acting insulin) FlexPen 100 U/1 ml solution per sliding scale before meals and bedtime. Novolin R FlexPen's Instructions for Use, revised 11/2022, indicated, Preparing your Novolin R included A. Pull off the pen cap; B. Remove the protective tab from a disposable needle. Screw the needle tightly onto your Novolin R FlexPen; C. Pull off the big outer needle cap; and D. Pull off the inner needle cap and dispose of it. The instructions revealed, Giving the airshot before each injection included Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to make sure you take the right dose of insulin, the instructions specified to E. Turn the dose to select 2 units; F. Hold your Novolin R FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; and G. Keep the needle pointing upwards, press the push-button all the way in [reference to a diagram]. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. The instructions specified, Selecting your dose included Check and make sure that the dose selector is set at 0; and H. Turn the dose selector to the number of units you need to inject. The instructions revealed, Giving the injection included I. Insert the needle into your skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer; and J. Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin [reference to a diagram]. This will make sure that the full dose has been given. Novolog injection pen's Instructions for Use revised 02/2023, indicated, Preparing your Novolog FlexPen included A. Pull off the pen cap; B. Attaching the needle, which specified, Remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen; C. Pull off the big outer needle cap; and D. Pull off the inner needle cap and throw it away. The instructions revealed, Giving the airshot before each injection included Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing, the instructions specified to E. Turn the dose selector to select 2 units; F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bubbles collect at the top of the cartridge; and G. Keep the needle pointing upwards, press the push-button all the way in [reference to a diagram]. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. The instructions revealed, Selecting your dose included Check and make sure that the dose selector is set at 0; and H. Turn the dose selector to the number of units you need to inject. The instructions revealed, Giving the injection included I. Insert the needle into your skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer; and J. Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin [reference to a diagram]. This will make sure that the full dose has been given. During a medication administration observation on 06/17/2026 at 10:33 AM, Licensed Practical Nurse (LPN) #4 opened a Novolog FlexPen for Resident #2, then without first applying a needle, turned the dial to an unknown amount, pushed the button, then applied the needle and turned the dial to 8. LPN #4 then opened Novolin R FlexPen for Resident #2, then without first applying a needle, turned the dial, to an unknown amount, pushed the button, then applied the needle and turned the dial to 7. LPN #4 was stopped by the surveyor prior to entering the resident's room and was questioned if the needle had been primed. LPN #4 stated the needle had been primed, and that was how she was trained. She stated that by turning the dial up to the ordered dose, the insulin was set and ready to go. LPN #4 administered 8 units with the Novolog FlexPen to the right arm and 7 units with the Novolin R FlexPen to the abdomen, and both injections were removed immediately with no wait time following the injection rather than waiting the required six seconds before removing the needle after administration. During an interview on 06/17/2026 at 3:22 PM, LPN #7 stated that it was important to prime the needle prior to setting the dose for administration, so the dose of insulin was accurate. During an interview on 06/17/2026 at 3:34 PM, the Director of Nursing (DON) stated she expected the medication error rate to be 0%. The DON stated she expected the dial on an insulin injection pen to be turned to two units when staff placed the needle on the pen in order to prime the needle before turning the dial to the physician-ordered dose. She stated that when administering insulin, she expected the nurse to wait three to five seconds before removing the needle. The DON stated the nurse should have primed the needle and waited before removing the needle. The DON stated that the importance of waiting to remove the needle was to ensure all the insulin was administered. The DON stated the importance of priming the needle was to ensure the ordered dose of insulin was administered. During an interview on 06/17/2026 at 4:11 PM, the Administrator stated he expected the medication error rate to be less than 5%. The Administrator stated he expected the insulin needle to be primed and to wait to ensure the insulin was fully administered.

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Highland Park Health Care	1307 R D Miller Drive Okmulgee, OK 74447

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, record review, and facility policy review, the facility failed to ensure an accurate code status was reflected throughout the medical record for 1 (Resident #3) of 22 residents reviewed for advance directives.Findings included: A facility policy titled, Advanced Directives, revised 02/12/2022, indicated, 5) Resident wishes will be communicated to the staff via the care plan.6) The resident's physician will be notified of the resident's advance directive decisions.7) During the quarterly Resident Assessment Instrument (RAI) process and with any significant changes of condition, facility staff will:a) Identify, clarify and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directiveb) Define and clarify medical issue, review the resident's condition and existing choices and present information regarding relevant health care issues to the resident or resident representative as appropriate to determine continuation or modification of choices of care, ande) Changes to the resident choices for advanced directives will be documented, included in the resident plan of care, State specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable, and all items will be communicated to staff providing resident care. A Record of Admission revealed the facility admitted Resident #3 on 02/29/2024. Resident #3's Record of admission indicated, Advanced Directives: Code Status - Full Code, DNR [Do Not Resuscitate]. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/14/2026, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #3's Plan of Care - Current included a problems/strengths statement, effective 10/13/2025, that indicated, Advance Directive - [Resident #3's name] has chosen to be a DNR. Interventions directed staff to:- Ensure Advanced Directives were discussed and appropriate paperwork was obtained (effective 05/01/2025);- Notify the physician and representative of any changes in the resident's condition (effective 05/01/2025);- Discuss and confirm the resident's advanced directive choices with the resident and/or responsible party or representative upon admission, quarterly, or as indicated (effective 05/01/2025);- Ensure advance [sic] directives are discussed and appropriate paperwork is provided to resident and placed in medical record (effective 05/01/2025);- Keep a copy of the MOST [Medical Orders for Scope of Treatment, a portable, physician-signed medical order] form in the medical record; and- Send a copy of the MOST form with the resident when sending out to the hospital or to other nursing facility. Resident #3's Plan of Care - Current indicated, Code Status - Full Code; DNR at the bottom of each page. Resident #3's Physician's Orders, dated from 08/01/2025 through 06/17/2026, included: D/C [discontinue] Code Status - Full Code, ordered 03/05/2025 and discontinued 12/17/2025 and Code Status - Full Code and May use AED [automated external defibrillator], ordered 12/17/2025. Resident #3's Physician's Orders revealed Advanced Directives: DNR; Code Status - Full Code at the bottom of each page. Resident #3's Physician's Telephone Order[s] included orders:- Code Status - Full Code, started 03/05/2025 at 5:17 PM and discontinued 12/17/2025 at 12:52 PM;- Discontinue Code Status - Full Code, and Stop date 12/17/2025 time 12:52 [PM]; and- Code Status - DNR and Start date: 06/17/[20]26 09:19 [AM] and D/C [discontinue] date: 06/17/2026 12:00 [PM]. Resident #3's Care Plan Conference/Discharge Planning minutes, dated 04/13/2026, indicated the resident was present for the meeting and that code status was discussed, however, the code status listed was Full Code; DNR. Resident #3's Interdisciplinary Progress Notes, dated 08/26/2025, 09/29/2025, 02/26/2026, 03/30/2026, 04/30/2026, and 05/28/2026 indicated the resident remained, Full Code. An observation of the inside of Resident #3's closet door, on 06/17/2026 at 9:52 AM, revealed a sheet of red paper inside a sheet protector that read, Medical Alert, DNR. During an interview on 06/17/2026 at 11:01 AM, the Director of Nursing (DON) stated the inconsistent code status information could result in the resident not receiving resuscitation if they wanted it or receiving resuscitation when they did not want it. During (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 06/17/2026 at 11:30 AM, the Minimum Data Set (MDS) Coordinator stated she was responsible to update the care plan and MDS reports and she did not review physician's orders when completing that process. The MDS Coordinator indicated that an adverse outcome related to getting a code status incorrect would be death or the other way around. During an interview on 6/17/2026 at 2:35 PM, the Doctor of Osteopathic Medicine (DO) stated if the care plan was confusing for staff a resident who needed to be coded might not be coded. During an interview on 06/18/2026 at 12:49 PM, the Administrator stated, There is zero gray area when it comes to code status. It has to be correct, and that is my expectation.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on facility policy review, facility document review, a review of a sit-to-stand mechanical lift manufacturer's manual, observation, and interview, the facility failed to ensure 1 of 3 mechanical lifts at the facility were maintained in safe working condition and stored according to manufacturer instructions.Findings included: An undated policy titled, Maintenance Service, revealed Maintenance service shall be provided to all areas of the building, grounds, and equipment. The policy revealed, 1. The maintenance department is responsible for maintaining buildings, grounds, and equipment in a safe and operable manner at all times. An undated facility document titled, Emergency Procedures Lock-Out/Tag-Out revealed, Goal is to ?lock-out' machinery and equipment from its power source prior to maintenance to avoid accidents that occur from start-up or release of stored energy. The document revealed, Lock-out devices and tags should only be removed by the person who applied them or the person servicing them. The Owner's Operator and Maintenance Manual for the facility's sit-to-stand mechanical lift, dated 02/05/2018, revealed, Do not store the lift in a damp area or in a camp condition. Periodically inspect all components for signs of correction and replace those that are corroded or damaged. The manual revealed, If you question the safety of any part of the life, contact your dealer immediately and advise them of the problem. The manual revealed, Regular cleaning will reveal loose or worn parts, enhance smooth operation and extend the life expectancy of the lift. The manual included Section 7-Troubleshooting which included Symptoms, Faults, and Solution. The manual revealed an example of a symptom of Stand up life feels loose, which indicated Faults included Mast/base joint loose and Tie rods are loose. The manual revealed a Solution included to Tighten the bolt, washer and locknut that secure the mast to the base. During an interview on 06/16/2026 at 9:12 AM, Certified Nurse Aide (CNA) #3 stated mechanical lifts were stored in shower rooms. During an observation on 06/16/2026 at 9:20 AM, the facility's sit-to-stand mechanical lift was observed in a shower room. The lift exhibited peeling paint, a missing screw, and instability of the handles. Reddish-brown residue was present on portions of the equipment, and debris and hair accumulation were present in the wheels. During a concurrent observation and interview on 06/16/2026 at 11:58 AM, the Assistant Director of Nursing (ADON) evaluated the sit-to-stand mechanical lift and stated the equipment was missing a bolt and should not have been in service. The ADON stated the sit-to-stand lift was not being used for any residents at the time. She stated that she would put a tag on it for maintenance staff to follow up on. During a concurrent observation and interview on n 06/17/2026 at 12:05 PM, the Regional Director of Plant Operations (RDPO) stated shower rooms were considered damp environments due to steam, condensation, and humidity, and equipment not designed for such conditions should not be stored in those locations due to risk of deterioration and reduced function. The RDPO stated maintenance activities were tracked through an electronic system, and inspections were expected to be completed routinely. The RDPO stated equipment identified as not functioning properly should be removed from service. The RDPO stated that lock-out/tag-out procedures for mechanical lifts included removal of critical components, such as the battery and controller, and application of signage indicating the equipment was out of service. The RDPO stated routine cleaning of equipment was the responsibility of housekeeping staff. During the interview, the RDPO evaluated the sit-to-stand mechanical lift and stated the equipment exhibited instability of the handles and surface deterioration, and that debris and hair accumulation were present in the wheels. He revealed that the lift was also missing a pin in the mast, which supported the actuator and battery. The observation revealed that a Do Not Use had been placed on the lift. During a concurrent observation and interview on 06/17/2026 at 12:25 PM, the Director of Nursing (DON) stated equipment should not be stored in damp environments, such as shower rooms, when not in use. The DON stated equipment identified as broken must be removed from service, labeled with an Out of Order sign, documented in the maintenance log, reported to maintenance and leadership staff, and then stored safely until repaired. The DON evaluated the sit-to-stand mechanical lift and stated (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that rust, dirt, and hair were present on the sit-to-stand mechanical lift and that the condition was unacceptable. During an interview on 06/17/2026 at 2:25 PM, the Administrator stated staff were expected to report malfunctioning equipment immediately, enter concerns into a maintenance log, and notify a supervisor. The Administrator stated equipment must be stored according to facility policy and manufacturer guidance and should not be placed in damp environments, such as shower rooms. The Administrator stated storage limitations existed, and that efforts were in progress to increase storage capacity.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on facility policy review, facility document review, observation, and interview, the facility failed to ensure the daily staff posting information was accurately completed for staff directly responsible for resident care for 17 (06/01/2026 through 06/17/2026) of 17 days reviewed. This had the potential to affect all 74 residents who resided in the facility.Findings included: A facility policy titled, Daily Nurse Staffing Information, revised 01/12/2020, revealed, The CMS [Centers for Medicare and Medicaid Services] required staffing information sheet will be posted in a public area of the nursing facility, as required. The policy revealed, 1. Daily including weekends and holidays, the number of FTEs [full time equivalents] for care staff will be calculated and documented on the facility's Daily Nurse Staffing form. The policy indicated, 2. The facility shall post the following information on a daily basis, which included A. Facility Name; B. Current Date; C. Resident census; and D. The actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift; which included i. Registered Nurses; ii. Licensed practical nurse or licensed vocational nurses (as defined under State Law; and iii. Certified nurse aides (including Certified Medication Aides [CMAs] if the CMAs are Certified Nursing Aides). The policy specified, E. The shift time are to be added and the calculated FTEs. FTEs are based on an 8-hour shift. The policy indicated, 4. The staffing sheet needs to be corrected as needed for staffing changes occurring throughout the 24-hour period. During an observation at the nurses' station on 06/15/2026 at 10:00 AM, the Daily Staffing Sheet-Clinical Department document that was posted revealed the census was left blank. During an observation at the nurses' station on 06/16/2026 at 10:30 AM, the Daily Staffing Sheet-Clinical Department document that was posted revealed the census was left blank. During an observation at the nurses' station on 06/17/2026 at 7:53 AM and 8:10 AM, the Daily Staffing Sheet-Clinical Department document that was posted revealed the census was left blank. The facility's Daily Staffing Sheet-Clinical Department documents, for the timeframe from 06/01/2026 through 06/17/2026, revealed the following:- 06/01/2026- The document only contained scheduled nursing hours, but not actual hours worked. The census and the total hours for each shift were left blank.- 06/02/2026- The document only contained scheduled nursing hours, but not actual hours worked for the night shift (11:00 PM to 7:00 AM). The total hours for each shift were left blank.- 06/03/2026- The document only contained scheduled nursing hours, but not actual hours worked for the evening shift (3:00 PM to 11:00 PM) and the night shift. The total hours for each shift were left blank.- 06/04/2026 through 06/14/2026- The documents only contained scheduled nursing hours, but not actual hours worked. The census and the total hours for each shift were left blank. During an interview on 06/17/2026 at 9:36 AM, Licensed Practical Nurse (LPN) #7 stated that the process for the daily staff posting was for the Staffing Coordinator to put out the schedule and nursing staff to assign the halls. She stated that the Staffing Coordinator left the sheet for the night shift nurse, and the nurse posted the sheet. She stated that the sheet was completed for the residents to know where the staff were working for the day. LPN #5 stated that the census should be filled, and actual hours worked should be completed. She stated that the daily staffing sheet was for anyone coming into the building to see how many staff were there, where the staff was working, and how many nursing hours were provided for each resident. During an interview on 06/17/2026 at 9:42 AM, the Staffing Coordinator stated that she filled out the staffing sheet, but she did not assign the staff. She stated that she did not fill out the actual hours because she was not sure if a staff member called in. She stated that the census should be filled out by the Administrator. She reviewed the daily posted staffing sheet for 06/17/2026 and stated that the census should be completed. The Staffing Coordinator stated that the form was completed for staff to know where they were assigned. She stated she received very little training on the daily staffing form due to being pulled to work the floor or the medication cart. During an interview on 06/17/2026 at 10:04 AM, The Director of Nursing (DON) stated the daily staffing sheets listed every person who was working and the hours they were to (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	work. She stated the sheet was completed so that staff knew their assignment, and residents or their families knew who would be providing their care, and the facility could ensure sufficient staffing hours to cover the resident census. She stated her expectation for the daily staffing sheets was for the Staffing Coordinator or nursing staff to fill out the hours accurately and to make changes to them in the event of staff call-ins. During an interview on 06/17/2026 at 12:30 PM, the Administrator stated he had read the facility's policy regarding the daily staff posting, and his expectations were for the census and actual hours to be totaled each shift.