STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375528	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Suites Healthcare	3501 W Washington Street Broken Arrow, OK 74012

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interview, the facility failed to ensure resident assessments were accurate for 4 (#44, 57, 69 and #87) of 21 sampled residents reviewed for MDS accuracy.The administrator identified 74 residents resided in the facility.Findings:A facility document titled MDS Completion and Submission Timeframes, dated October 2023, read in part, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.1. A quarterly assessment for Res #57, dated 11/01/25, showed section C: cognitive patterns had not been completed.On 02/12/26 at 9:57 a.m., the MDS coordinator stated Res #57's section C of the MDS was answered not assessed. The MDS coordinator stated they should have been answered and assessed.2. An admission assessment for Res #87, dated 11/21/25, showed section C: cognitive patterns had not been completed.On 02/12/26 at 9:46 a.m., the MDS coordinator stated Res #87's section c of the MDS was answered not assessed. The MDS coordinator stated they should have been answered and assessed.3. An annual assessment for Res #44, dated 12/11/25, showed section C: cognitive patterns had not been completed.On 02/12/26 at 9:51 a.m., the MDS coordinator stated Res #44's section C of the MDS was answered not assessed. The MDS coordinator stated they should have been answered and assessed.4. A quarterly assessment for Res #69, dated 12/12/25, showed section C: cognitive patterns had not been completed.On 02/12/26 at 9:54 a.m., the MDS Coordinator stated Res #69's section C of the MDS was answered not assessed. The MDS coordinator stated they should have been answered and assessed.On 02/12/26 at 1:31p.m., the DON stated they could not explain why section C was not completed. The DON stated section C should have been assessed and answered correctly.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to electronically submit resident assessments to CMS for 2 (#13 and #27) of 2 sampled residents reviewed for MDS submission.The administrator identified 74 residents resided in the facility.Findings:A MDS Completion and Submission Timeframes policy, dated 10/01/23, read in part, The assessment coordinator or designee is responsible for ensuring resident assessments are submitted to CMS' Internet Quality Improvement Evaluation System in accordance with current federal and state guidelines.1. A discharge assessment for Res #27, dated 11/07/25, showed the assessment had not been submitted to CMS.2. An annual assessment for Res #13, dated 12/30/25, showed the assessment had not been submitted to CMS.On 02/10/26 at 1:55 p.m., the MDS coordinator stated the MDS assessments for Res #13 and Res #27 were not submitted to CMS by the RN who reviewed and signed the assessments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure quarterly care plan meetings were held for 2 (#34 and #45) of 2 sampled residents reviewed for care plan meetings.The administrator identified 74 residents resided in the facility. Findings: A Resident Participation – Assessment/Care Plans policy, dated 11/01/25, showed the resident and/or the resident's representative were encouraged to participate in the development and implementation of the resident's care plans. 1. An admission record, dated 07/21/17, showed Res #34 had diagnoses which included multiple sclerosis and dementia. An annual assessment, dated 10/28/25, showed Res #34 had a BIMS score of 14 which indicated they were cognitively intact. A review of the health record for Res #34 showed their last care plan meeting was held on November 2024. On 02/09/26 at 11:06 a.m., Res #34 stated the facility had not been having care plan meetings. On 02/11/26 at 1:51 p.m., the SSD stated they had not completed quarterly care plan meetings as required. On 02/12/26 at 10:40 a.m., the DON stated care plan meetings should be held upon admission, every quarter, and as needed. 2. A quarterly assessment, dated 01/02/26, showed Res #45 had a BIMS score of 13 which indicated they were cognitively intact. The assessment showed Res #45 had diagnoses which included stroke and hypertension. The health record for Res #45 showed the last care plan meeting was held on 05/03/24. On 02/09/26 at 2:11 p.m., Res #45's family member stated they had not had any care plan meetings. They stated a care plan meeting was scheduled for last month but was canceled because no staff were available to attend at the scheduled time. Res #45's family member stated they were informed by staff they were trying to get back to having regular care plan meetings. On 02/11/26 at 1:51 p.m., the SSD stated they have not been having quarterly care plan meetings as required. On 02/12/26 at 10:40 a.m., the DON stated care plan meetings should be held upon admission, every quarter, and as needed.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review and interview, the facility failed to ensure an explicit statement was included in the arbitration agreement which stated the residents were not required to sign to be admitted for 3 (#47, 67, and #95) of 3 sampled residents reviewed for binding arbitration agreements.The administrator identified 74 residents resided in the facility.Findings:A Binding Arbitration Agreements policy, dated 11/2023, read in part, Binding arbitration agreements are voluntary for the residents. Residents are not compelled, pressured, or coerced to enter into a binding arbitration agreement. It is unambiguously communicated to residents (or representatives) that binding arbitration agreements are optional and not required as a condition of admission or to receive care at this facility.1. A facility arbitration agreement for Res #95, dated 04/02/25, was signed by the resident's representative on 04/15/25. The agreement, read in part, the execution of this Arbitration agreement is not precondition to the furnishing of services to the Resident by the Facility.2. A facility arbitration agreement for Res #67, dated 07/28/25, showed the resident's representative refused to sign the document as noted by the SSD. The agreement, read in part, the execution of this Arbitration agreement is not precondition to the furnishing of services to the Resident by the Facility.3. A facility arbitration agreement for Res #47, dated 01/07/26, was signed by the resident on 01/07/26. The agreement, read in part, the execution of this Arbitration agreement is not precondition to the furnishing of services to the Resident by the Facility.On 02/12/26 at 12:34 p.m., the SSD stated the portion of the facility's binding arbitration agreement that used the language furnishing of services did not clearly state admissions to the facility was not dependent on signing the agreement instead of general services offered by the facility. They stated their wording was not clear enough.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on record review and interview, the facility failed to ensure binding arbitration agreements provided to residents and/or representative to sign including a stipulation for a neutral arbitrator to be chosen by both parties and for a venue for the arbitration at a location that is convenient to both parties for 3 (#47, 67, and #95) of 3 sampled residents reviewed for binding arbitration agreements.The administrator identified 74 residents resided in the facility.Findings:A Binding Arbitration Agreements policy, dated 11/2023, read in part, Arbitration agreements provide for the selection of a neutral arbitrator, which is agreed upon by both parties. A neutral arbitrator is an impartial, unbiased, third-party decision maker, without the appearance of any conflicts of interest, contracted with and agreed to by moth parties to resolve their dispute.Arbitration agreements provide for the selection of a venue that is convenient to and suitably meets the needs of bother parties. The venue will be agreed upon by both parties. When selecting a venue for consideration, 'convenience' for the resident (or representative) may be determined by his or her ability to get to the venue.1. A facility arbitration agreement for Res #95, dated 04/02/25, was signed by the resident's representative on 04/15/25. A review of the agreement showed there was no stipulation in the document regarding the mutual selection of an arbitrator between the facility and the resident. The agreement did show that if neither party agreed on a venue site the arbitration would occur at the facility.2. A facility Arbitration Agreement for Res #67, dated 07/28/25, showed the resident's representative refused to sign the document as noted by the SSD. A review of the agreement showed there was no stipulation in the document regarding the mutual selection of an arbitrator between the facility and the resident. The agreement did show that if neither party agreed on a venue site the arbitration would occur at the facility.3. A facility arbitration agreement for Res #47, dated 01/07/26, was signed by the resident on 01/07/26. A review of the agreement showed there was no stipulation in the document regarding the mutual selection of an arbitrator between the facility and the resident. The agreement did show that if neither party agreed on a venue site the arbitration would occur at the facility. On 02/12/26 at 12:34 p.m., the SSD was asked to review the facility's binding arbitration agreement and to describe the portions regarding arbitrator and venue selection. They stated they did not read anything about the process of choosing an arbitrator. They stated the venue would be selected mutually but if they could not agree arbitration would occur at the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to use enhanced barrier precautions when performing peg tube (a type of feeding tube inserted into the stomach through the abdominal wall) care, peg tube feeding, and the administration of medication via peg tube for 1 (#86) of 1 sampled resident reviewed for a feeding tube.The DON identified two residents had a feeding tube.Findings:On 02/11/26 at 8:37 a.m., Res #86 was observed in bed sleeping. Res #86's room had no signage for enhanced barrier precautions, and no personal protective equipment was readily accessible to staff near the room.On 02/11/26 at 1:25 p.m., LPN #2 was observed to enter Res #86's room, performed hand hygiene, applied gloves, and checked for peg tube placement. LPN #2 inserted a syringe into the peg tube to check for residual. LPN #2 returned the residual into the peg tube and flushed with 50 cc of water. LPN #2 held the feeding since the residual was over 100 cc. LPN #2 did not wear a gown, the required enhanced barrier precautions for the attempted feeding.On 02/12/26 at 8:26 a.m., RN #1 was observed to enter Res #86's room, washed their hands, applied gloves, and used a syringe check for residual through the peg tube. RN #1 administered scheduled medication and feeding via the peg tube. RN #1 discarded their gloves and supplies into the trash, washed their hands, and exited the resident's room. RN #1 did not wear a gown for the required enhanced barrier precautions.On 02/12/26 at 12:30 p.m., RN #1 was observed to enter Res #86's room, washed their hands, applied gloves, and performed a dressing change to the peg tube site. RN #1 discarded their gloves and supplies into the trash, washed their hands, and exited the room. RN #1 did not wear a gown for the required enhanced barrier precautionsAn Enhanced Barrier Precautions policy, dated 04/01/25, showed enhanced barrier precautions apply when a resident had a wound or an indwelling medical device. The policy showed indwelling medical devices included feeding tubes. The policy showed a gown and gloves were required to be worn for feeding tube care or use.A physician's order for Res #86, dated 07/24/25, showed for feeding tube check residuals by aspiration of stomach contents four times a day before feedings.A physician's order for Res #86, dated 07/25/25, showed to cleanse the peg tube site with dermal wound cleanser, pat dry, and apply a drain sponge, and secure with tape every shift.A quarterly assessment for Res #86, dated 11/06/25, showed the resident's cognition was severely impaired and the BIMS could not be scored. The assessment showed a feeding tube and a diagnosis of a transient ischemic attack (ministroke).A treatment administration record for Res #86, dated 02/01/26 through 02/28/26, showed no order for enhanced barrier precautions.On 02/12/26 at 11:55 a.m., the DON stated enhanced barrier precautions should be used for residents with peg tubes when providing direct care, administering medication via the peg tube, and performing a peg tube feeding. The DON stated Res #86 required enhanced barrier precautions (gown and gloves) to be worn by staff when care was performed.On 02/12/26 at 12:30 p.m., RN #1 stated they failed to wear a gown when performing Res #86's peg tube dressing change, feeding, and medication administration. RN #1 stated enhanced barrier precautions should have been used for Res #86.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure ongoing side effect monitoring was completed for a resident receiving a psychotropic medication for 1 (#19) of 5 sampled residents reviewed for unnecessary medications.The DON identified 60 residents received psychotropic medications. Findings:An undated facility policy titled Monitoring and Reduction of Unnecessary Medications Related to Side Effects in Long-Term Care Residents, read in part, The facility is committed to minimizing unnecessary medications and ensuring that all medications are used safely, effectively, and in accordance with federal and state regulations. Staff must proactively monitor side effects, document findings, and collaborate with providers to adjust or discontinue medications when appropriate.A physician's order for Res #19, dated 08/29/25, showed the resident was to receive fluoxetine 10 milligrams (an antidepressant) by mouth every day.A quarterly assessment for Res #19, dated 12/12/25, showed the resident had a BIMS score of 12 which indicated moderate cognitive impairment. The assessment showed Res #19 routinely received an antidepressant.A care plan intervention for Res #19, dated 12/31/25, showed the resident had depression and medications were to be administered as ordered and side effects and effectiveness were to be monitored and documented.A treatment administration record for Res #19 was reviewed from 08/29/25 through 2/10/26. No documentation of side effect monitoring was located.On 02/11/26 at 2:21 p.m., the DON stated that no side effect monitoring took place for Res #19.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the OSDH and local law enforcement within two hours of becoming aware of the allegation for 1 (#10) of 3 sampled residents reviewed for abuse.The administrator identified 74 residents resided in the facility.Findings:A facility Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation - F609 policy, dated 2001, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as require by current regulations) and thoroughly investigated by facility management. The policy showed reports of allegations of abuse would be made within two hours.An initial incident report form, incident date 01/27/26, showed on 01/27/26 the facility staff were made aware by a family member of an alleged act of abuse against Res #10. The incident report showed the administrator reported the incident to the OSDH and local law enforcement on 02/03/26.On 02/04/26 at 12:30 p.m., the administrator stated they were made aware of the allegation on 02/03/26 during a morning staff meeting by the DON. They stated the DON had reported finding out about the incident on 01/27/26. The administrator stated when they learned about the allegation, they immediately made the required reports on 02/03/26. They stated the reports should have occurred on 01/27/26 when staff were informed by the family.On 02/04/26 at 12:32 p.m., the DON stated they told the administrator of the alleged abuse regarding Res #10 at the staff meeting on 02/03/26 and should have done it earlier.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to ensure an allegation of abuse was investigated timely and the alleged perpetrator was prevented from working with the alleged victim until the conclusion of the investigation for 1 (#10) of 3 sampled residents reviewed for abuse.The administrator identified 74 residents resided in the facility.Findings:A facility Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation - F609 policy, dated 2001, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as require by current regulations) and thoroughly investigated by facility management. The policy showed staff was to ensure the alleged perpetrator and victim were kept apart and the alleged perpetrator was to be placed on leave until completion of an investigation.An initial incident report form, incident date 01/27/26, showed on 01/27/26 facility staff were made aware by a family member of an alleged act of abuse against Res #10. The incident report showed the administrator reported the incident to the OSDH and local law enforcement on 02/03/26.A facility document titled Individual Timesheet, dated 02/04/26, showed CNA #1 had worked at the facility on 01/29/26, 01/30/26, and 01/31/26. Those dates followed the date the DON had been made aware of the allegation of abuse against CNA #1 and before the administrator began their investigation on 02/03/26. On 02/04/26 at 11:48 a.m., the DON stated they had learned about the accusation of abuse during a care plan meeting on 01/27/26. They stated they were informed by the family member the alleged perpetrator was CNA #1. The DON stated they had told the administrator about the incident but could not recall what day they had done so.On 02/04/26 at 12:30 p.m., the administrator stated they learned of the allegation against CNA #1 on 02/03/26 during a morning staff meeting by the DON. They stated when the DON had informed them on 02/03/26 they suspended the CNA #1 while they performed the investigation.On 02/04/26 at 12:42 p.m., the DON stated CNA #1 had not worked at the facility since their shift on 01/31/26. They stated they should have begun the investigation when they first learned about the allegation and immediately suspended the nurse aide.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to provide a written notice of transfer to a resident discharged to an acute care facility prior to transfer for 1 (#92) of 3 sampled residents reviewed for discharges.The DON identified 60 residents discharged during the three months prior to the survey.Findings:A facility Transfer or Discharge policy, dated April 2025, did not include the requirement to notify the resident or their representatives in writing prior to transfer or discharge.A nurse's note for Res #92, dated 01/03/26, showed at 11:23 a.m., the resident was sent to an acute care hospital for behaviors.On 02/11/26 at 1:19 p.m., LPN #1 stated they had not heard of a written notice of transfer and had never given one to any of the residents they had transferred or discharged .On 02/11/26 at 1:22 p.m., the DON stated they were unaware of the requirement for a written notice of transfer to be given to a resident or their representative prior to transfer or discharge. They stated they had not been providing those notices to residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed for 1 (#91) of 20 sampled residents reviewed for comprehensive care plans.The administrator identified 74 residents resided in the facility.Findings:A facility Care Plans, Comprehensive, Person-Centered policy, dated March 2022, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy showed the comprehensive care plans were to be completed within seven days of completion of the required MDS assessment and no more than 21 days after admission to the facility.An admission record for Res #91, dated 10/07/25, showed the resident had been admitted to the facility on [DATE] and discharged on 11/23/25.An admission assessment for Res #91, dated 10/14/25, showed the resident was admitted to the facility on [DATE]. A review of the electronic medical record of Res #91 showed no comprehensive care plan had been developed.On 02/11/26 at 12:24 p.m., the MDS coordinator was asked to locate Res #91's comprehensive care plan. The MDS coordinator stated they could not find a comprehensive care plan in Res #91's electronic medical record. They stated the resident had been in the facility long enough where the care plan should have been developed. They stated the care plan should have been completed no later than 14 days after the admission MDS assessment had been completed.On 02/11/26 at 12:48 p.m., the DON stated they could not locate a comprehensive care plan for Res #91. They stated their expectation and facility policy mandated the comprehensive care plan would be developed within 14 days of the completion of a resident's comprehensive assessment.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. Based on observation, record review, and interview, the facility failed to have a qualified activity director. The administrator identified 74 residents resided in the facility.Findings:On 02/09/26 at 2:42 p.m., residents were observed in the dining area playing bingo with an automated bingo machine that was calling the bingo numbers with CMA #3 sitting at the table.On 02/11/26 at 12:02 p.m., the activity board was observed. The board showed the facility was to have coffee and conservations every Monday and Friday at 10:45 a.m., bible study every Tuesday at 10:45 a.m., and stretch every Thursday at 10:45 a.m.On 02/11/26 at 1:15 p.m., residents were observed sitting at various tables playing bingo with an automated game that called out the numbers for the game.An undated facility Resident Rights poster showed the facility would provide a program of activities designed to meet the residents needs and interests.On 02/11/26 at 1:40 p.m., the social worker stated either they or another staff member would assist with activities. They stated they did not know how long the facility had been without an activity director.On 02/11/26 at 1:45 p.m., the administrator stated currently they did not have a fulltime activity director. The administrator stated it had been some weeks since they had an activity director. They stated they were in the process of hiring an activity director.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure refrigerator temperatures were recorded for 1 (medication room [ROOM NUMBER]) of 2 medication refrigerators observed for safe storage of medication.The DON identified two medication rooms with medication storage refrigerators in the facility.Findings:On 02/10/26 at 9:33 a.m., medication room [ROOM NUMBER] was observed with the DON. Inside the medication room was a full-size refrigerator that contained medications and did not have a temperature record log attached for February 2026. A facility Storage of Medications policy, dated 2001, read in part, Drugs and biologicals used in the facility are stored in locked compartments and under proper temperature, light and humidity controls.On 02/10/26 at 10:11 a.m., the DON stated they searched and were unable to locate the missing temperature log for the medication refrigerator located in medication room [ROOM NUMBER]. They stated the log should have been kept on the refrigerator and filled out completely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375528	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Suites Healthcare	3501 W Washington Street Broken Arrow, OK 74012

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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a urine sample was not stored in a refrigerator used to store resident food for 1 (medication room [ROOM NUMBER]) of 2 sampled medication room food storage refrigerators observed for infection control.The administrator identified 74 residents resided in the facility.Findings: On 02/10/26 at 9:33 a.m., a mini refrigerator located in medication room [ROOM NUMBER] was observed to have a box of bacon, two protein shakes, one individual sized ice cream, two mighty shakes, and one urine specimen cup filled halfway with a yellow substance and sealed in a plastic lab bag. The cup had the name of a former resident written on it. The specimen cup and bag were laying on top of the ice cream and mighty shakes container. On 02/10/26 at 9:37 a.m., DON stated the food inside the mini refrigerator located in medication room [ROOM NUMBER] was to store resident food items. They stated the urine specimen cup should not have been stored in that refrigerator. They stated it was an infection control issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375528	A. Building B. Wing	02/12/2026

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the call light was operational for 1 (#94) of 3 sampled residents whose call lights were tested.The administrator identified 74 residents resided in the facility.Findings:On 02/10/26 at 9:05 a.m., Res #94 was observed to push their call light to test it. The light outside of the resident's room above the door did not light up or sound. The resident had no bell to ring for assistance.On 02/10/26 at 9:06 a.m., the monitor connected to the call lights at the nurses' station did not display Res #94's room number.On 02/11/26 at 9:24 a.m., an observation of the maintenance logbook at the nurses' station showed no call lights that needed to be fixed.On 02/11/25 at 9:25 a.m., CNA #5 was observed to document in the maintenance logbook that the call light in Res #94's room was not working, and the call light in room [ROOM NUMBER] was not working.An Answering the Call Light policy, dated 09/01/22, read in part, Ensure that the call light is plugged in and functioning at all times.Report all defective call lights to the maintenance director or administration to get them addressed promptly. A baseline care plan for Res #94, dated 02/06/26, showed the resident required stand-by assist with ambulation.On 02/10/26 at 9:05 a.m., Res #94 stated their call light did not work. Res #94 stated maintenance had replaced the cord, but it was still not working.On 02/10/26 at 9:08 a.m., CMA #3 stated when the call light was pushed, the light above the door would come on, and the room number was also displayed on the monitor at the nurses' station. CMA #3 stated the lights and monitors did not always work.On 02/11/26 at 9:23 a.m., Res #94 stated their call light was still not working.On 02/11/26 at 9:24 a.m., the DON stated a new maintenance logbook was put in use at each nurses' station to report things needing to be fixed.On 02/11/26 at 9:26 a.m., CNA #5 stated the call light in Res #94's room was not working. CNA #5 stated they had issues with the call lights not working almost daily.On 02/12/26 at 10:29 a.m., the administrator stated there were issues with the facility's call light system. The administrator stated residents were given a bell to ring if the call light could not be fixed.On 02/12/26 at 10:32 a.m., the DON stated no documentation was available of maintenance being notified previously of call lights not working. They stated it was done verbally. The DON stated Res #94's call light and the call light in room [ROOM NUMBER] had been fixed on 02/11/26 before 3:00 p.m.