STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375582	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. On 08/13/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure supervision was provided to a resident who smoked and used oxygen that resulted in Resident #20 igniting themselves and received second degree burns to their face.On 08/13/25 at 5:09 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 08/13/25 at 5:23 p.m., the administrator and the DON were notified of the IJ situation and the IJ template was provided.On 08/14/25 at 11:40 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Incident: Resident was smoking while wearing oxygen and accidentally ignited [themself], resulting in burn injuries and immediate life-threatening risk.1. Immediate Action Taken- Oxygen was removed from the resident's vicinity and turned off to eliminate fuel source. Staff responded immediately, extinguishing the fire, and activated emergency medical response, first aid was provided at the facility prior to transport. Resident transferred to the emergency department for burn evaluation/treatment.2. Identification of All Residents at Risk- Facility wide audit within 2 hours to identify all residents who use oxygen and smoke. Each identified resident immediately educated on fire risks and safe practices. Residents using oxygen prohibited from smoking without staff present; oxygen removed at least 10 feet for 10 minutes from ignition source before lighting any smoking material.3. Education- 07/17/2025: All staff and residents were in-serviced on the smoking policy, confiscating smoking materials, lighting equipment and vapes. Fire drills were carried out per CMS and NFPA regulations. Competency verified through verbalization of hazard recognition. 08/13/2025 at 6:50 p.m.: All staff educated on the importance of communications of hazard identification related to smoking and oxygen supervision. Staff is to immediately communicate if a resident is placing themselves in danger.4. Systemic Changes to Prevent Recurrence- Smoking Policy revised to mandate staff removal of oxygen and confirmation of safe distance and time frame before resident smokes. Care plan updated for all residents who smoke. Maintenance to inspect and ensure No Smoking Oxygen in Use is posted and visible in all relevant areas.If a resident is observed attempting to smoke with oxygen in place- Staff will immediately notify licensed nurse on duty- staff will 1:1 resident until licensed nurse arrives.- Licensed nurse will assess respiratory status prior to oxygen removal.- Licensed nurse will remove the oxygen tubing/tank from the resident before smoking in accordance with the facility smoking policy.- Licensed nurse will notify Administrator, Director of Nursing, or designee immediately.Any staff member who observes a resident not following the smoking policy will immediately:- Immediately notify the nurse on duty.- Remain with the resident until the nurse arrives to prevent unsafe action.- Licensed nurse will:Intervene to stop unsafe behavior and secure any smoking materialsNotify the Admin/DON or designee immediatelyDocument the incident and interventions in the resident's medical record.5. Monitoring & QASupervised smoking will continue for all residents.Any non-compliance will be clearly documented with results reported to QAPI: corrective action taken immediately if deviation noted.6. Completion Date for Immediate Jeopardy RemovalAll immediate corrective actions completed by 08/14/25 at 2:00 p.m.The IJ was lifted, effective 08/14/25 at 2:00 p.m., when all components of the plan of removal had been completed. Multiple staff on different (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	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	shifts were interviewed regarding the in-service they received; and audits were reviewed. In-services and fire drills were reviewed. The revised smoking policy was reviewed. Care plans were reviewed, and no smoking signs were observed in designated areas. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to ensure supervision was provided to a resident who smoked and used oxygen for 1 (#20) of 4 sampled residents reviewed for accidents.The administrator identified 53 residents resided in the facility, 6 residents smoked and wore oxygen frequently/routinely, and 14 residents smoked and had as needed orders for oxygen.Findings:An undated Smoking and Oxygen Use Policy-Long-Term Care Facility, read in part, Residents have the right to smoke if medically cleared; however, safety must be prioritized when oxygen therapy is involved. The facility may limit or revoke smoking privileges for residents who are noncompliant with safety protocols . Residents must be removed from oxygen for at least 10 minutes before smoking. Smoking is only permitted in the designated outdoor smoking areas under staff supervision. Oxygen equipment must be stored away from the smoking area. Staff must verify that the resident has complied with the disconnection time before allowing smoking.An undated order summary showed Resident #20 had diagnoses which include hypoxemia, congestive heart failure, and chronic obstructive pulmonary disease.An evaluation Smoking and Safety, dated 12/14/24, showed Resident #20 had balance problems while sitting or standing. The evaluation did not have any clinical suggestions marked.A physician's order, dated 12/16/24, showed oxygen at 4 liters per minute via nasal cannula three times a day.A care plan, initiated 02/14/25, showed Resident #20 required supervision while smoking and to ensure residents' oxygen was removed and turned off before smoking.A care plan, revised, 05/18/25, showed Resident #20 smoked independently and required supervision while smoking.A care plan, initiated, 07/17/25 and revised on 07/21/25, showed Resident #20 was noncompliant with smoking while oxygen in use, with goal for resident to be free from complications related to noncompliance. The care plan showed only one intervention of the resident placed on 1:1 related to smoking with the use of oxygen, educate resident on importance of not smoking while oxygen in use related to safety. An Initial INCIDENT REPORT FORM, dated 07/17/25, showed serious harm. The report showed the resident went to the front of the building and told the receptionist they were going outside for fresh air. The report showed once resident was outside, they lit a cigarette while they were wearing their oxygen cannula. The report showed the oxygen caught on fire and they were sent to the emergency room for evaluation and treatment.A behavior note, dated 07/17/25 at 12:52 p.m., read in part, Resident observed preparing to go outside to smoke with nasal canula in place. Informed resident of the risk associated with smoking while using oxygen, including fire hazard. Resident was advised not to smoke while on oxygen therapy. Will continue to reinforce safety precautions. Supervisor notified.A facility incident report, dated 07/17/25 at 2:45 p.m., read in part, Resident [#28] came wheeling to the nurses station fast, stated [Resident #20] set [themselves] on fire. [They] were smoking cigarette with [Their] oxygen on. Went to front door found [Resident #20] sitting in wheel chair. Face burn along nose and lips, and neck area. Awake and alert, non-compliant, explained to resident earlier no smoking because of oxygen.An incident note, dated 07/17/25 at 3:56 p.m., read in part, Resident outside smoking with oxygen on and caught face on fire. Noted blackened areas to face and nose. Bottom lip is swollen and small amount of red substance noted. EMSA [emergency medical services authority] here resident transported to [hospital] burn center via stretcher.An After Visit Summary, dated 07/17/25 - 07/19/25, showed Resident #20 had second degree burn of face.A Smoking and Safety, evaluation, dated 07/18/25, showed Resident #20 had poor vision or blindness. It did not have any clinical suggestions or interventions marked.A Smoking and Oxygen use, in-service, dated 07/18/25 showed 8 staff signatures. Resident #20's discharge return anticipated resident assessment, dated 07/30/25, showed the resident's cognition had modified independence with decision making, required supervision to substantial assistance with mobility. The assessment did not show the resident smoked.There was no documentation of staff supervision while resident smoked outside.On 08/12/25 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 8:15 a.m., Resident #20 was asked what happened to their face. They stated, I got burned smoking with oxygen on. They stated there were not any nurses outside when the incident occurred. Resident #20 stated they were outside without any supervision for about 30 minutes. They stated there was somebody outside but they were on their phone. Resident #20 stated a lot of the time people would be out there smoking and no ones with them. They stated they get the code to the door so they go out there and smoke without the staff out there. They stated they get their smoking material from the nurse. On 08/12/25 at 1:38 p.m., the activity assistant stated there were seven designated times for residents to smoke and the residents had to wait at the nurse's station for the designated staff to pass out the cigarettes to them one at a time and the staff has the lighter. The stated they were supervised by either staff staying outside or watching through the window. The activity assistant stated they were aware of the smoking incident with Resident #20 but had no knowledge if they were supervised at the time of the incident. The activity assistant stated there was only one resident to their knowledge that was an independent smoker, and it was not Resident #20. On 08/12/25 at 2:03 p.m., CNA #1 stated the whole building watches for smokers. They stated the residents had a lock box the materials were kept in and it was separated by each resident. CNA #1 stated Resident #20 required encouragement to not smoke due to breathing problems and oxygen. CNA #1 stated the resident was upset the day of the incident. CNA #1 stated the last time they saw Resident #20 that day, they were sitting up front by the tv at the table. CNA #1 stated the resident was always moving around. CNA #1 stated they heard the RN on duty (whom did not return phone calls for interview) state they were sending Resident #20 out because they set themselves on fire. CNA #1 stated it occurred around lunch time, and they had signed themselves out and went out the front and no staff was with them. Unable to speak to the RN that sent resident out to the hospital as they did not answer the phone, and the nurse that made the note of the resident preparing to go outside with oxygen was no longer employed at the facility since the date of the incident. On 08/13/25 at 11:54 a.m., Resident #20's family member #1 stated they did not provide the resident with a lighter and that the last time they had visited Resident #20 was on Saturday the 2nd and had brought snacks only. On 08/13/25 at 12:19 p.m., Resident #20's family member #2 stated they did not provide the resident with any smoking material and they do not purchase the cigarettes for them. They stated they last visited the resident two weeks ago. On 08/13/25 at 12:37 p.m., LPN #2 stated Resident #20 did not normally leave the facility and if they did, it was with their family member. They stated Resident #20 were normally in their room or the tv room and would sit outside for fresh air. LPN #2 stated they were aware of the recent smoking incident, and the resident was currently out of cigarettes and had tried to be sneaky to get from another resident. LPN #2 reviewed the sign out books, dated for 07/11/25 - 07/22/25, for Resident #20's name. LPN #2 stated the resident didn't typically sign out and were always on the back smoking area. The resident sign out book showed the resident had signed out on 07/14/25 at unknown time and another with an unknown date with a time frame of 8:45 a.m., and for 07/14/25 with a family member. LPN #2 stated no resident went out with their cigarettes without staff during smoking time. On 08/13/25 at 1:24 p.m., the administrator and DON were interviewed. The administrator stated after reviewing the nurse note from 07/17/25, their expectation regarding interventions to prevent hazard from smoking while on oxygen was the residents don't have lighters, and the tanks were to be turned completely off on the wheel chair before they were allowed to go smoke. The DON interjected and stated 90% of the time they were the one to remove the tank and put it in the dining room until the resident came back in. The administrator stated the implemented interventions when the resident was observed preparing to go outside to smoke while wearing oxygen was they talked to the resident about the dangers. The administrator stated nothing showed the resident attempted at that moment with that staff member to go outside. The administrator stated Resident #20 was very evasive to staff members and if they said no, the resident would roll around the building until someone that doesn't know. They stated the resident did not say they were going out to smoke, and they did not see any smoking material on them.On 08/13/25 at 1:30 p.m., both the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	administrator and the DON stated a resident should not be allowed to smoke with the intent they will still be on their oxygen.On 08/13/25 at 1:32 p.m., the administrator stated they did not do any resident safe surveys at the time of the incident on 07/17/25. They stated the incident could have affected other residents. They were unaware of how the resident obtained the smoking material. The administrator stated residents that were mentally capable could check themselves out as they could not keep them trapped in the property and they had the right to leave and had a right to their property and do their due diligence to get them upon their return. The administrator stated no resident was allowed to smoke independently, even independent smokers, and if they sign out it was off property, all had been educated, and Resident #20 had been educated multiple times.On 08/13/25 at 1:34 p.m., the administrator stated Resident #20 could sign themselves out. The administrator stated they did not see where the resident was signed out for 07/17/25. They stated the residents were not required to sign out to get fresh air or while on the property.On 08/13/25 at 3:03 p.m., the administrator stated they ensure resident safety while outside on premises by frequent observations and frequent checks, I can't keep them locked in.On 08/13/25 at 3:07 p.m., CNA #5 stated the last time they were in-serviced regarding the smoking protocol and safety was when they first started in May.The hire date for CNA #5 was 05/05/25 per the employee list with hire dates provided by the administrator.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident was free from abuse for 1 (#8) of 3 sampled residents reviewed for abuse.Findings:On 08/11/25 at 10:10 a.m., Resident #8 was observed sitting in a wheelchair in their room. The resident had a knot and bruising on the right side of their forehead. On 08/11/25 at 11:00 a.m., Resident #4 was observed lying in their bed with their eyes closed. On 08/11/25 at 12:10 p.m., Resident #4 was observed in the dining room with a one-on-one sitter. On 08/12/25 at 9:13 a.m., Resident #4 was observed lying in their bed with their eyes closed. An annual assessment, dated 05/30/25, showed Resident #4 was admitted to the facility on [DATE] with diagnoses to include dementia with agitation, Alzheimer's disease, and major depressive disorder. The assessment showed Resident #4 had a BIMS of 15, which indicated Resident #4 was cognitively intact. An annual, dated 06/03/25, showed Resident #8 was admitted to the facility on [DATE] with diagnoses to include cerebrovascular accident (stroke), anxiety, depression, and schizophrenia. The assessment showed Resident #8 had a BIMS of 14, which indicated Resident #8 was cognitively intact. An Incident Note, dated 08/09/25, read in part, Resident states that the other resident [Resident #4] was sitting in [their] spot in the dining room. [They] told [Resident #8] [they] normally don't sit here. Other resident [Resident #4] stated that [they] was going to sit wherever [they] like and it's not nothing [Resident #8] could do about it. Both residents started passing word between each other. This resident [Resident #4] stated that the other resident [Resident #8] said I would hit you with this cane and this resident [Resident #4] stated and I will stick you with this fork. The other resident [Resident #8] hit this resident [Resident #4] over the head with the cane. Resident has a hematoma on the right side of head. The note showed Resident #4 declined transport to the emergency room for evaluation and neurological checks were initiated by staff. Both residents were separated. A review of Resident #4's electronic medical chart showed neuro checks were provided by licensed staff through 08/10/25 and Resident #4 was seen by a physician on 08/11/25. A document titled 15 Minute Checks, dated 08/11/25, showed Resident #8 was placed on one-on-one supervision on 08/11/25 through 08/12/25. On 08/11/25 at 10:10 a.m., Resident #8 was asked how they received the knot and bruising to the right side of their forehead. Resident #8 stated, I got to the dining room, and [Resident #4] was sitting in my spot; the same spot I've sat in for 6 months. I told [Resident #4] [they] were in my spot. [They] said, 'I don't want to hear that shit, find you somewhere else to sit.' [Resident #4] said 'I'm not getting up,' so that's when the argument started. Resident #8 stated that Resident #4 kept raising [their] cane as if [they] were going to hit Resident #8 with it. Resident #8 stated, I said you better not hit me with that cane. [They] brought it up and hit me in the head on the right side. Resident #8 was asked what the staff's response was to the incident. Resident #8 stated, To my knowledge they got [Resident #4] on one-on-one, but I don't know what that means. [Resident #4] is not allowed to come in here in my room and that's all I know. Resident #8 was asked if a nurse checked them out after they were hit. Resident #8 stated, Yes and my head is really sore and swollen. Resident #8 was asked if staff were giving them anything for pain and they stated, I ask for Tylenol and they give it to me. On 08/12/25 at 1:01 p.m., CMA #3 was asked what they knew about Resident #8's bruising on their head. CMA #3 stated, I wasn't here. Just what I was told is [Resident #8] and [Resident #4] got into an altercation and [Resident #4] hit [Resident #8] with their cane. CMA #3 was asked if Residents #4 and #8 had gotten into an altercation before this incident. CMA #3 stated, No. [Resident #8] just got to this hall last week. CMA #3 was asked what interventions were put into place for the residents. They stated, I'm not sure. On 08/12/25 at 1:06 p.m., CMA #1 was asked what they knew about Resident #8's bruising on their head. CMA #1 stated, I just know what [Resident #8] told me. They said [Resident #4] was sitting in [Resident #8's] spot, told [them] to move and [Resident #8] got hit in the head. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CMA #1 was asked what interventions were in put into place for the residents. CMA #1 stated, [Resident #4] is supposed to have a one-on-one sitter, but I don't know for how long. On 08/12/25 at 2:15 p.m., CMA #2 was asked what they knew about Resident #4. They stated, [Resident #4] has moments, but if something doesn't go [their] way or [they're] disagreeing with someone that's when things happen. CMA #2 was asked what interventions were implemented for Resident #4 when they are agitated. CMA #2 stated, Separate [them], walk with [them]. That usually works. Try to meet [their] needs. CMA #2 was asked how many altercations Resident #4 had with other residents. CMA #2 stated, Just had one this past weekend, but I haven't heard anything else. CMA #2 was asked what interventions were implemented after his altercation with Resident #8. They stated, Separation, one-on-one, and [their] family came. On 08/12/25 at 2:34 p.m., a phone call was placed to the nurse on duty during Residents #4 and #8's altercation on 08/09/25. LPN #3 was asked what they knew about the incident. LPN #3 stated, There was a commotion in the dining room. When we made it in there [Resident #8] had a big knot on [their] head and said [Resident #4] had hit them with a cane. LPN #3 identified the aide in the dining room as CNA #2. LPN #3 was asked what interventions were put into place following the incident. LPN #3 stated, We separated them and [Resident #8] sat at the nurse's station with me. On 08/12/25 at 2:52 p.m., a phone call was placed to CNA #2, and they were asked about the incident between Residents #4 and #8. They stated, It happened in the dining room. [Resident #8] didn't want [Resident #4] to sit next to [them] and started throwing a fit. [Resident #4] hit [Resident #8] with a cane, so [Resident #8] grabbed a fork, but was unable to make contact with [Resident #4]. CNA #2 was asked what interventions were put into place following the incident. They stated, The nurses were called and tried calming everyone down and the residents were separated. On 08/12/25 at 3:09 p.m., the DON was asked what they knew about the incident between Residents #4 and #8. They stated, [Resident #4] sat in [Resident #8's] seat and wouldn't move. An argument ensued and [Resident #4] wacked [Resident #8] on the head with [their] cane, causing a knot on [Resident #8's] head. The DON was asked what interventions were put into place following the incident. The DON stated, At that time we talked about the one-on-one, making sure the two residents weren't near each other. The DON stated the staff relocated Resident #4 to a different hall.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on record review and interview, the facility failed to ensure the staff informed residents who attended the resident council meetings were informed of where past survey results were located in the facility. Findings:A review of the resident council meeting minutes from January 2025 through July 2025 showed no education to residents regarding the location of past facility survey results.On 08/12/25 at 9:59 a.m., the residents gathered for a resident council interview were asked if they knew where the past facility survey results were located without having to ask staff. The residents stated, No, in unison and shook their heads indicating no.On 08/18/25 at 11:07 a.m., the social services director, who helped organize resident council meetings, was asked how it was communicated to the residents where the past survey results were located. They stated, I don't know that it is communicated. They've never asked. The social services director was asked if they had ever made residents aware of where the results were located. They stated, No.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food served to the residents from the kitchen was palatable.The ADON identified 50 residents received nutrition from the kitchen.Findings:A lunch menu for 08/11/25 showed the residents would be served beef teriyaki, white rice, sugar snapped peas, choice of roll, and lemon bars.On 08/11/25 at 12:46 p.m., residents were observed being served a beef steak patty with white gravy instead of beef teriyaki in the dining room.On 08/11/25 12:47 p.m., a resident not included in the survey sample was served their plate and was overheard stating to their table mate, This is one of those days I wish I had money to Door Dash food.On 08/11/25 at 12:52 p.m., Resident #28 was observed having difficulty cutting the beef patty and pushed their plate away.On 08/11/25 12:59 p.m., Resident #4 stated to their one-on-one sitter they can't cut the meat. Resident #4's one-on-one sitter was then observed cutting Resident #4's beef patty.On 08/11/25 at 1:04 p.m., Resident #8 was observed to have eaten 25% of their lunch plate. On 08/11/25 at 1:23 p.m., surveyor attempted to cut a beef patty with white gravy on top. Using all of hand strength, it took one solid minute to cut into the beef patty. The beef patty did not taste fresh, was not easily chewed, and was bland. The edges of the beef patty appeared to be burned.On 08/11/25 at 12:54 p.m., Resident #28 was asked if they normally have a hard time cutting meat. They stated, Yes, but today it's really hard. On 08/11/25 at 1:04 p.m., Resident #8 was asked how their lunch tasted. Resident #8 stated, It was horrible. Awful. I couldn't even chew this mystery meat.On 08/11/25 1:24 p.m., the dietary manager was asked to cut a piece of the beef patty. The dietary manager tried cutting it three times and stated, I can't cut it. They were asked if they taste the food they cook before serving it to the residents. The dietary manager stated, Normally I do, but I didn't today. The dietary manager was asked if they would expect a resident to be able to cut the beef patty on their own. They stated, No.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to inform residents and/or their representatives of the risk, benefits, and alternative treatment options for psychotropic medications for 5 (#4, 7, 28, 33, and #34) of 5 sampled residents whose clinical records were reviewed for unnecessary medications. The ADON identified 14 residents received psychotropic medications.Findings: An undated facility policy titled, Use of Psychotropic Medication(s), read in part, Prior to increasing or initiating a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication. 1. An undated transfer/discharge report showed Resident #28 had diagnoses which included adjustment disorder with anxiety depressive episodes, psychosis, schizoaffective disorder, and conversion disorder with seizures. A physician order, dated 04/04/25, showed Resident #28 received bupropion (an antidepressant medication) 150mg tablet daily for depression. A physician order, dated 05/01/25, showed the Resident #28 received trazodone (an antidepressant medication) 150mg at bedtime for depressive episodes. A quarterly assessment, dated 05/25/25, showed Resident #28 had a BIMS of 15 and was receiving antipsychotic, antianxiety, and antidepressant medications. A physician order, dated 06/24/25, showed the Resident #28 was to receive trazodone 50 mg at bedtime to be given with the trazodone 150mg to make 200 mg. A physician order, dated 07/04/25, showed the Resident #28 was to receive aripiprazole (an antipsychotic medication) 15mg at bedtime for adjustment disorder with mixed anxiety and depressed mood. A physician order, dated 07/25/25, showed the Resident #28 was to receive trazodone 100 mg at bedtime and to be given with the trazodone 150mg to make 250mg. The records for Resident #28 did not document the resident or the resident's representative was informed of the risk, benefits, or alternative treatment options for the use of psychotropic medications. 2. An undated face sheet showed Resident #33 had diagnoses which included schizoaffective disorder, disorders of the brain, anxiety disorder, and depression. A physician order, dated 11/28/23, showed Resident #33 was to receive haloperidol (an antipsychotic medication) 5mg at bedtime for hallucinations related to schizoaffective disorder. A significant change assessment, dated 06/05/25, showed Resident #33 had a BIMS of 14. The assessment showed Resident #33 received antipsychotic, antianxiety, and antidepressant medications. (continued on next page)

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	375582	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 07/16/25, showed Resident #33 was to receive Zoloft (an antidepressant medication) 50mg daily for depression. The records for Resident #33 did not document the resident or the resident's representative was informed of the risk, benefits, or alternative treatment options for the use of psychotropic medications. 3. A MAR for August 2025 showed Resident #34 was admitted to the facility on [DATE] with diagnoses to include other recurrent depressive disorder, post-traumatic stress disorder, and generalized anxiety disorder. The MAR for August 2025 showed Resident #34 was receiving the following medications Cymbalta (an antidepressant) 20mg two capsules by mouth one time daily for post-traumatic stress disorder. Cymbalta was initiated on 08/21/24. buspirone HCL (an anxiolytic) 5mg two tablets two times daily for anxiety. Buspirone HCL was initiated on 06/18/25. Doxepin HCL (an antidepressant) 6mg one tablet by mouth at bedtime for other recurrent depressive disorder. Doxepin 6mg was initiated on 06/20/25. Doxepin HCL (an antidepressant) 10mg one tablet by mouth at bedtime for depression. Doxepin 10mg was initiated on 07/25/25. Trazadone HCL (an atypical antidepressant) 50mg one tablet by mouth at bedtime for insomnia. Trazadone was initiated on 07/25/25. A review of Resident #34's medical chart showed no psychotropic medication education or consent for the medications was given to the resident or representative. 4. A MAR, dated August 2025, showed Resident #7 was admitted to the facility on [DATE] with diagnoses to include major depressive disorder, pseudobulbar effect, and post-traumatic stress disorder, and was receiving escitalopram oxalate (an antidepressant) 15mg by mouth one time daily for major depressive disorder. The Escitalopram oxalate was initiated on 05/18/25. A review of Resident #7's medical chart showed no psychotropic medication education or consent for the medications was given to the resident or representative. 5. A MAR for August 2025 showed Resident #4 was admitted to the facility on [DATE] with diagnoses to include dementia with agitation, Alzheimer's disease, and major depressive disorder. The MAR for August 2025 showed Resident #4 was taking the following antipsychotic medications. sertraline (an antidepressant) 25mg two tablets one time daily for depression. Sertraline was initiated on 07/25/25, and Zyprexa (an atypical antipsychotic) 15mg one tablet by mouth one time a day for depression. The Zyprexa was initiated on 07/30/25. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #4's medical chart showed no psychotropic medication education or consent for the medications was given to the resident or representative. On 08/13/25 at 12:02 p.m., the ADON was asked where the consents for psychotropic medications for all residents would be found. The ADON stated to the DON, Your office or [social services director], but should be in your office. The DON stated, There's nothing in there. On 08/13/25 at 12:03 p.m., the ADON asked the social services director if they had consents for psychotropic medications. The social services director stated, No, they should be in the DON's office. On 08/13/25 at 12:05 p.m., the DON stated, The consents should be in PCC. The DON was asked to show where in the electronic medical chart the psychotropic drug consents were located. The ADON stated, [The DON] may not have been entered yet. The DON stated, I will see if I can find them. On 08/13/25 at 12:11 p.m., the ADON stated, [The nurse practitioner] from [psychiatric service company] said [they] received verbal consents, and the [social services director] was to send signed consents. On 08/13/25 at 12:12 p.m., the social services director was asked to confirm they did not have any drug consents. They stated, Yes, that is correct. They were asked if obtaining consents for psychotropic drug medication was ever asked of them to do. They stated, No, it's not. I do talk to the lady from the psych [psychiatric service company] who sees the residents, but I don't do anything with medications. That would be the DON. On 08/13/25 at 12:32 p.m., the DON stated, Psych service stated the psychotropic consent is under general consent in documents on PCC. The general consent was shown to the DON and asked where it mentioned psychotropic medications. The DON read over it and stated, Oh, that's just what I was told. I guess we don't have them.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure:a. a PRN psychotropic medication was limited to 14 days for 1 (#3) of 5 sampled residents reviewed for PRN medications, andb. psychotropic medications were discontinued per orders for 2 (#28 and #34) of 5 sampled residents reviewed for psychotropic medications.The ADON identified 14 residents in the facility received psychotropic medications.Findings:1. An undated transfer/discharge report showed Resident #28 had diagnoses which included adjustment disorder with anxiety depressive episodes, psychosis, schizoaffective disorder, and conversion disorder with seizures. A physician order, dated 04/04/25, showed the Resident #28 received bupropion (an antidepressant medication) 150mg tablet daily for depression. A physician order, dated 05/01/25, showed the Resident #28 received trazodone (an antidepressant medication) 150mg at bedtime for depressive episodes. A quarterly assessment, dated 05/25/25, showed Resident #28 had a BIMS of 15 and was receiving antipsychotic medication, antianxiety medication, and antidepressant medication. A physician order, dated 06/24/25, showed Resident #28 was to receive trazodone 50 mg at bedtime to be given with the trazodone 150mg to make 200 mg. A physician order, dated 07/04/25, showed Resident #28 was to receive aripiprazole (an antipsychotic medication) 15mg at bedtime for adjustment disorder with mixed anxiety and depressed mood. A physician order, dated 07/25/25, showed Resident #28 was to receive trazodone 100 mg at bedtime and to be given with the trazodone 150mg to make 250mg. On 08/14/25 at 3:21 p.m., LPN #2 viewed Resident #28's physician orders and stated the trazodone medication should have been clarified. They stated the computer notifies them for repeat medications on the medication administration record. On 08/14/25 at 3:36 p.m., the CMA #1 stated they did not see a notification for the repeat orders for the trazodone medication on the medication administration record. The ACMA stated Just give what is listed. On 08/14/25 at 3:43 p.m., the DON stated the trazodone medication given was a medication error and the staff should have questioned and clarified the physician order. The DON stated it was a med error, and the staff should have caught the error and addressed. 2. An undated facility policy titled Use of Psychotropic Medication(s), read in part, PRN orders for psychotropic medications shall be limited to no more than 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the for the extended time period and indicate a specific duration. An annual assessment, dated 06/03/25, showed Resident #3 was admitted to the facility on [DATE] (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with diagnoses to include anxiety disorder, bipolar disorder, and schizophrenia. A Hospice Physician Order, dated 07/10/25, read in part, Lorazepam (a psychotropic medication) 0.5mg Take one tablet every four hours PRN agitation. There was no end date for this medication. A review of Resident #3's MAR for July 2025 showed Resident #3 was administered on a PRN basis Lorazepam 0.5mg 22 times between 07/12/25 and 07/29/25. There was no end date for this medication on Resident #3's MAR. A review of Resident #3's MAR for August 2025 showed Resident #3 was administered on a PRN basis Lorazepam 0.5mg 30 times between 08/01/25 and 08/15/25. There was no end date for this medication on Resident #3's MAR. A review of Resident #3's medical record did not contain any documentation from a physician or prescriber a rationale for extended use of the PRN psychotropic medication or an end date for the medication. On 08/18/25 at 9:25 a.m., the ADON was asked what the facility's policy was on PRN psychotropic medications. They stated, It's a 14 day stop date on PRN psychotropics. The ADON was shown Resident #3's August MAR where Resident #3's PRN Lorazepam was prescribed on 07/10/25 and they were asked what the stop date was for Resident #3's PRN Lorazepam. The ADON stated, There's not one. The ADON was asked what date the PRN Lorazepam should have been stopped and the ADON stated, The 25th of July. 3. A MAR for August 2025 showed Resident #34 was admitted to the facility on [DATE] with diagnoses to include other recurrent depressive disorder, post-traumatic stress disorder, and generalized anxiety disorder. The MAR for August 2025 showed Resident #34 was taking Doxepin HCL (an antidepressant) 6mg one tablet by mouth at bedtime for other recurrent depressive disorder. Doxepin 6mg was initiated on 06/20/25. The MAR for August 2025 showed Resident #34 was taking Doxepin HCL (an antidepressant) 10mg one tablet by mouth at bedtime for depression. Doxepin 10mg was initiated on 07/25/25. A Physician's Order, dated 07/25/25, read in part, Start Doxepin 10mg, give one capsule p.o. (by mouth) at h.s. (bedtime). Stop Doxepin 6mg p (medical abbreviation for after) the 10mg is available. A refill request for Doxepin 6mg, dated 07/25/25, read in part, Please send refill. 0 in building, The request was signed by LPN #1. A document titled Recommendation Summary for DON and Medical Director, dated 08/04/25, read in part, This resident [Resident #34] is currently prescribed the following medications: Doxepin 6mg QHS (every bedtime) for the treatment of depression and Doxepin 10mg QHS for the treatment of depression. Administering these medications together may be considered duplicate therapy. The combination of these medications may increase the resident's risk of adverse effects and associated negative health outcomes. Is the resident supposed to be on both of these Doxepin orders? A review of the document did not show the DON or medical director reviewed this recommendation. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/25 at 1:37 p.m., LPN #1 was asked what the procedure was when a resident does not have a medication available. They stated, Call the pharmacy to order to find out what's going on. LPN #1 was asked who was responsible for checking the physician's orders for residents. They stated, I'm not sure about that. Somebody in management probably. LPN #1 was shown Resident #34's refill request for Doxepin 6mg and asked if the signature of the person requesting the refill was theirs. They stated, Yes it is. [Resident #34] was out. LPN #1 was asked if they were aware of any other Doxepin orders Resident #34 had. They stated, [Resident #34] has two different orders for Doxepin. 10mg and 6mg. LPN #1 was asked to read the physician's order dated 07/25/25. They read, Start Doxepin 10mg one p.o at h.s. Stop doxepin 6mg and the 10 is available. LPN #1 pointed to the medical abbreviation for after and asked, What does that mean? Oh, I didn't know what that meant. I didn't know we were supposed to DC (discontinue) the 6mg. On 08/13/25 at 1:44 p.m., the ADON was asked who was responsible for verifying physician orders. They stated, Most of the time it's me. The ADON was shown Resident #34's Recommendation Summary for DON and Medical Director and was asked if Resident #34 was supposed to be on both doses of Doxepin. They stated, Yes. The ADON was asked how recommendations from the pharmacy get to the physician. They stated, I put them in this book. The ADON was asked how often the physician was at the facility. They stated, Every Friday. The ADON was asked to check the book they place the pharmacy recommendations in to see if the physician had reviewed and signed the recommendation for the duplicate Doxepin order. They stated, It's not in this book, so it should be in the stack for medical scanning. On 08/13/25 at 2:02 p.m., the ADON was informed the pharmacy recommendation document signed by the physician was not in the pile to scanned and they asked where else it might be. The ADON stated, That I don't know. We probably don't have it. The ADON was asked what the policy was for sending pharmacy recommendations to the physician. They stated. We put them in his book as soon as we get them so they can sign them. The physician's order dated 07/25/25 to DC the Doxepin 6mg was shown to the ADON and they were asked to read the order. They then stated, Oh, he was supposed to stop the 6mg.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record review, and interview, the facility failed to maintain confidentiality of resident records for 1 observation during medication administration observation. The administrator identified 53 residents resided in the facility. Findings:On 08/18/25 at 11:44 a.m., and observation of an unattended medication cart in the hallway of hall 200 with the laptop opened, unlocked, and showed resident names.An undated policy titled Confidentiality of Personal and Medical Records, read in part, This facility honors the resident's right to secure and confidential personal and medical records .Keep Confidential is defined as safeguarding the content of information including written documentation, video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative.On 08/18/25 at 11:45 a.m., CMA #4 was asked what the policy and procedure was for ensuring the confidentiality of resident records. They stated, Should have locked it, that's my fault.On 08/18/25 at 11:50 a.m., the DON stated the process for maintaining confidentiality of records regarding the laptops on the medication carts was if they were not close to the laptop, they needed to lock it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to accurately code MDS assessment data for 2 (#7 and #45) of 22 residents whose MDS assessments were reviewed.Findings: 1.An annual assessment, dated 06/03/25, showed Resident #7 was admitted to the facility on [DATE] with diagnoses to include cerebrovascular accident and muscle wasting and atrophy. The MDS assessment showed Resident #7 required substantial/maximal assistance with eating, meaning the staff lifts or holds trunk or limbs and provides more than half the effort. A Care Plan Report, dated 06/15/25, showed Resident #7 required set up, clean up and supervision assistance by one staff to eat. On 08/14/25 at 10:20 a.m., CNA #1 was asked what was Resident #7's eating and drinking ability. They stated, [They] are able to eat and drink with [their] left hand. CNA #1 was asked if Resident #7 required help with eating or drinking. They stated, Just set up. On 08/14/25 at 10:29 a.m., LPN #2 was asked what help Resident #7 required for eating and drinking. They stated, [Resident #7] uses [their] left hand to eat and drink. We just open things for [them]. On 08/14/25 at 10:50 a.m., the MDS coordinator was asked what their process was for ensuring MDS assessments and care plans were correct and match one another. The MDS coordinator stated, The MDS transfers to the care plan. They were asked who conducted the assessments and the MDS coordinator stated, Myself. The MDS coordinator was shown Resident #7's MDS assessment and care plan and asked which one was correct regarding their eating ability. The MDS coordinator stated, [Resident #7] is a1 person assist. [Resident #7] uses [their] left hand to eat and drink. The MDS coordinator was asked if the MDS assessment or care plan were accurate and they stated, The care plan is accurate. 2. On 08/12/25 at 1:25 p.m., Resident #45 was observed to have a peg tube with dressing dated 08/12/25. A physician's order, dated 04/01/25, showed check residuals twice a day. If the residuals were greater than 100 ml, the feeding was to be held, and the primary care provider notified. The order showed to replace residuals two times a day. Resident #45's significant change resident assessment, dated 05/27/25, showed the resident had diagnoses which included gastrostomy status and Crohn's disease. The assessment did not document the resident had a peg tube. A physician's order, dated 07/24/25, showed enteral feed order four times a day. Bolus feed with one container jevity 1.5 (a liquid supplement) four times a day. On 08/12/25 at 1:20 p.m., LPN #1 stated Resident #45 had the peg tube since they started working at the facility three and a half months ago. On 08/12/25 at 1:50 p.m., MDS coordinator #1 stated if a resident had a peg tube, it should be coded on their MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/25 at 1:56 p.m., MDS coordinator #1 stated Resident #45's peg tube was not coded on the significant change resident assessment dated [DATE]. They stated it should be coded.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure:a. a physician's order for oxygen administration was followed for 1 (#45); andb. a resident had an order for the use of oxygen for 1 (#24) of 4 sampled residents reviewed for respiratory care.The administrator identified 4 residents on continuous oxygen use in the facility.Findings:1. On 08/11/25 at 3:28 p.m., Resident #45 was observed to be on 4.5 liters of oxygen via nasal canula.On 08/12/25 at 12:06 p.m., Resident #45 was observed to be on 4.5 liters of oxygen via nasal canula.An undated facility policy Oxygen Administration, read in part, Oxygen is administered under orders of a physician.A physician's order, dated 04/01/25, showed oxygen 2 liters via nasal canula every shift related to unspecified chronic obstructive pulmonary disease.Resident #45's significant change resident assessment, dated 05/27/25, showed the resident had diagnoses which included unspecified chronic obstructive pulmonary disease and unspecified heart failure. The assessment showed the resident's cognition was intact with a BIMS of 15. The assessment showed the resident used oxygen therapy.On 08/11/25 at 3:28 p.m., Resident #45 stated they were on 2 liters oxygen.On 08/12/25 at 1:21 p.m., LPN #1 stated they were in the resident's room around 8:00 a.m. and around 10:00 a.m. on 08/12/25. They stated they had offered the resident their medication and changed the peg tube dressing.On 08/12/25 at 1:23 p.m., LPN #1 stated they usually checked the resident oxygen saturation on their shift but had not done it yet. They stated the resident's average oxygen saturation was 97% on 2 liters.On 08/12/25 at 1:25 p.m., LPN #1 stated Resident #45 was supposed on be on 2 liters oxygen. They stated the rate was set to 4 liters. LPN #1 reduced the oxygen rate to 2 liters.On 08/12/25 at 1:34 p.m., the DON stated staff were to check oxygen saturation every shift, assess for respiratory distress and make sure the resident was on the ordered oxygen rate. 2. On 08/14/25 at 12:56 p.m., Resident #24 was observed on 3.5 liters of oxygen via nasal canula.Resident #24's admission resident assessment, dated 07/28/25, showed the resident was admitted on [DATE] and had diagnoses which included chronic obstructive pulmonary disease and unspecified heart failure. The assessment showed the resident's cognition was intact with a BIMS of 13. The assessment showed the resident used oxygen therapy.On 08/14/25 at 12:57 p.m., Resident #24 stated they were on 3 liters of oxygen since 12/2024. They stated they came to the facility about three weeks ago.On 08/14/25 at 1:01 p.m., Resident #24 stated staff only checked their oxygen when they asked.On 08/14/25 at 1:05 p.m., LPN #1 stated the Resident #45 was on oxygen since their admit and they checked their oxygen saturation each shift.On 08/14/25 at 1:06 p.m., LPN #1 stated they did not check the resident's oxygen saturation on this shift yet. They stated Resident #24's average oxygen saturation was above 90% on 2 liters. LPN #1 stated the resident was supposed to be on 2 liters of oxygen.On 08/14/25 at 1:07 p.m., LPN #1 observed Resident #24s concentrator. They stated the resident was on 3 liters of oxygen because the bottom of the concentrator flow meter ball was sitting on the 3 liters.On 08/14/25 at 1:09 p.m., LPN #1 stated Resident #24 did not have an order for the use of oxygen.On 08/14/25 at 1:10 p.m., the DON stated there should be an order for the use of oxygen.

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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 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. Based on observation, and interview, the facility failed to ensure expired medications were removed from stock for 1 of 1 medication storage room observation. The administrator identified 53 residents resided in the facility.Findings: An undated policy titled Handling and Disposal of Expired Medications, read in part, All medications maintained in the facility must be checked regularly for expiration dates. Expired or unused medications will be removed from active stock immediately, stored securely, and disposed of according to applicable regulations. On 08/18/25 at 8:51 a.m., the medication room was observed with CMA #1. There was expired medication in the refrigerator in the back of the medication room that faces the door to the room. Inside was expired medication for Resident #34 as follows: a. 3 Onelax (constipation) suppositories 10mg. Expiration date 12/17/24. b. 5 Acetaminophen (pain reliever) suppositories 650mg. Expiration date 12/17/24. On 08/18/25 at 8:52 a.m., CMA #1 stated night shift goes through the medication room to check for expired medications, but not sure how often. They stated resident #34 was still an active resident in the facility and the date on the medication was 12/17/24 for both the Onelax and Acetaminophen suppositories. CMA #1 stated the policy and procedure for expired medications was to remove it and write it on the discontinued paperwork. CMA #1 looked for any discontinued paperwork for the expired medication and did not find one had been written for Resident #34. They stated the CMAs were to write the expired medication on the discontinued form. On 08/18/25 at 9:13 a.m., the ADON stated the process for expired medications was to pull them off the cart if on there, then call the doctor to check to see if they want it renewed. The ADON stated then they put the expired medication in the medication storage room in a box they have for the discontinued medication and get rid of it at a later date. The ADON stated this was the same process for refrigerator stored expired medication as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375582	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure neutropenic precautions were followed for 1 (#39) of 1 sampled resident reviewed for neutropenic precautions.Findings:A Significant Change Assessment, dated 06/19/25, showed Resident #39 was admitted to the facility on [DATE] with diagnoses to include anemia and other pancytopenia (a disorder causing low levels of all three major blood cell types which increases risk of infection). On 08/11/25 at 3:41 p.m., a sign on Resident #39's closed door showed they were under neutropenic precaution (guidelines to protect individuals with pancytopenia from infection). This sign showed no live plants. Upon entering the resident's room, there were three live plants observed on Resident #39's windowsill. On 08/12/25 at 8:31 a.m., CNA #1 was observed wearing a mask entering Resident #39's room.On 08/18/25 at 10:07 a.m., LPN #1 was asked what neutropenic precautions needed to be taken for Resident #39. They stated, Wear a mask, no plants or fresh fruit. LPN #1 was asked how long Resident #39's live plants had been on their windowsill. LPN #1 stated, [Resident #39] has plants in there? I didn't notice. LPN #1 was asked why a resident on neutropenic precautions would require a staff member to wear a mask around them. They stated, To prevent infection, her immune system is compromised. On 08/18/25 at 10:09 a.m., the ADON was asked what neutropenic precautions meant. They stated, When you're taking care of [Resident #39] put on gloves, keep the door shut so everyone can see the (neutropenic precautions) sign on the door. The ADON was asked if someone was on neutropenic precautions, were they supposed to have live plants in their room. They stated, No. The ADON was asked how long Resident #39 had the plants in their windowsill. They stated, Probably before I started and I came in April.