STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375583	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parc Place Medical Resort	1400 East Memorial Road Oklahoma City, OK 73131

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 - Some	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 infection prevention control measures were in place for a. oxygen tubing labeled with the date and stored in a bag when not in use for 1 (#10) of 2 sampled residents reviewed for respiratory care;b. BIPAP mask labeled with the date and stored in a bag when not in use for 1 (#3) of 2 sampled residents reviewed for respiratory care;c. sanitary laundry delivery during 1 of 1 observation;d. legionella surveillance in the water system; ande. the use of enhanced barrier precautions when performing supra-pubic catheter care for 1 (#3) of 1 resident observed for urinary catheter care.The administrator identified 68 residents resided in the facility, 4 residents had BIPAPS, and 51 residents had orders for supplemental oxygen.The DON identified four residents with indwelling urinary catheters. Findings:An undated facility policy titled Noninvasive Ventilation (CPAP, BIPAP, AVAPS, Trilogy), read in part, The facility will obtain an order for the use of CPAP, BIPAP, AVAPS, or Trilogy device and settings from the practitioner.A personal CPAP, BIPAP, AVAPS, or Trilogy device may/may not be brought into the facility for the resident use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. 1. On 10/02/25 at 9:18 a.m., Resident #10 was observed resident in bed. Oxygen tubing and nasal cannula was observed rolled up and wrapped around the repositioning bar on the bed. The tubing was connected to an oxygen humidifier attached to the wall. There was no date observed on the oxygen tubing, the humidifier, or the nasal cannula indicating when they were administered. There was no date observed on the nasal canula, tubing, or humidifier. The nasal canula and oxygen tubing was not in a bag. Resident #10's physician orders, dated 09/08/25, read in part, Administer O2 to relieve shortness of breath and /or to breathe easier. Resident #10's admission assessment, dated 09/03/25, showed Resident #10's cognition was moderately impaired with a BIMS score of 9. The assessment showed Resident #10 was admitted on [DATE] with diagnoses which included acute respiratory failure and cerebrovascular disease. On 10/02/25 at 9:27 a.m., Resident #10 stated they wear oxygen as needed. On 10/02/25 at 10:25 a.m., CNA #1 stated they observed Resident #10's oxygen tubing tied and nasal cannula wrapped around Resident #10"s repositioning bar on their bed. CNA #1 stated the oxygen tubing with the nasal canula was attached to a humidifier bottle at the wall. CNA #1 stated the oxygen tubing, nasal cannula, and humidifier was not labeled with the date they were administered, and the nasal cannula was not bagged to prevent germs. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/25 at 10:31 a.m., RN #1 was asked what the policy was when administering oxygen tubing, nasal cannulas, and bi-pap treatments. RN #1 stated BIPAP mask and nasal cannulas should be bagged when not in use to protect from germs and cross contamination. RN #1 stated nasal cannulas, oxygen tubing, and the humidifier should be labeled with the date the equipment was administered and changed every 7 days. On 10/02/25 at 10:45 a.m., RN #1 stated they went to Resident #10's room and observed the nasal cannula and oxygen tubing was not labeled with the date they were administered. RN #1 stated they observed the nasal cannula and oxygen tubing not in use, wrapped around the repositioning bar on the residents' bed and it was not bagged to prevent cross contamination. On 10/02/25 at 10:50 a.m., the IP was asked to look in Resident #10's room and discuss what they observed. The IP stated the oxygen tubing and nasal canula were not in a bag and open to the air which has the potential for germs and infections. The IP stated the oxygen tubing, nasal cannula, and humidifier did not have the date they were administered. 2.On 10/01/25 at 1:30 p.m., LPN #1 was observed to provide catheter care to Resident #3. The LPN wore gloves but did not wear an isolation gown when they performed catheter care. On 10/02/25 at 9:31 a.m., Resident #3 was observed in lying in bed alert and oriented. A white BIPAP machine was observed on the bedside dresser. A mask and hose were observed attached to the BIPAP with visible moisture in the mask laying in the open top drawer of the bed side dresser. Resident #3's admission assessment, dated 09/19/25, showed Resident #3's cognition was intact with a BIMS score of 13. The assessment showed Resident #3 did not use a BIPAP or CPAP. The assessment showed Resident #3 was admitted on [DATE] with diagnoses which included paraplegia and stage 4 pressure ulcers. A care plan for Resident #3, revised 09/22/25, read in part, I understand that the staff has to wear a gown and gloves while providing care to me as an enhanced barrier protection (EBP) since I have an indwelling catheter to reduce the potential to spread bacteria (organisms) to other sites of my body or to other people. The care plan and physician orders for Resident #3 were reviewed. There were no physician orders, or a care plan focus on Residents #3's medical record for the resident's BIPAP usage. The order summary for Resident #3, dated 10/02/25, showed an order for the staff to perform catheter care every shift and as needed. The order was dated 09/12/25. The order summary for Resident #3, dated 10/02/25, showed an order for the staff to cleanse the resident's supra pubic catheter site with wound cleanser, pat dry, and apply a slit sponge gauze dressing every shift and as needed. The orders were dated 09/15/25. The order summary for Resident #3, dated 10/02/25, showed an order for EBP to be used twice daily and as needed. The orders were dated 09/12/25. On 10/02/25 at 9:30 a.m., Resident #3 stated the nursing staff did not wear an isolation gown when they performed catheter care, changed the slit drain sponge, or drained the catheter bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/25 at 9:31 a.m., Resident #3 stated they were admitted with the BIPAP machine and used it nightly to help them breathe. On 10/02/25 at 10:17 a.m., CNA #1 was asked about Resident #3's respiratory needs. CNA #1 stated Resident #3 had a BIPAP on their bedside table and the mask was in the top drawer not in a bag. On 10/02/25 at 10:50 a.m., the IP stated they observed a BIPAP with a mask with visible moisture and hose attached to the BIPAP on Resident #3's bed side dresser in an open drawer not in a bag. The IP stated there was not a physician order or care plan focus on Resident #3's medical record for BIPAP therapy. The IP stated the mask should be bagged when not in use to prevent germs and spread of infection. On 10/02/25 at 11:15 a.m., LPN #1 stated they did not recall catheter care required the use of EBP. On 10/02/25 at 11:20 a.m., the DON stated EBP was used with anybody that had a line, wound, or break in their body, to protect the resident from possible infection. The DON agreed when staff performed supra-pubic catheter care, the facility required the staff to use EBP. 3. On 10/01/25 at 8:00 a.m., laundry aide #1 was observed to deliver laundry to resident rooms uncovered. On 10/02/25 at 8:21 a.m., the housekeeping supervisor, stated resident clothes were washed separately and delivered back to their rooms in their own bag. They stated laundry aide #1 did not put the clothes in the bag. They stated they were aware of the incident on 10/01/25 at 8:00 a.m. 4. An undated policy Legionella Surveillance, read in part, It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections. An undated policy Water Management Program, read in part, It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens .in the facility's water systems based on nationally accepted standards .A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing .The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder. On 10/02/25 at 9:10 a.m., the maintenance supervisor stated they had no facility map of the water flow in the facility. The maintenance supervisor stated they added sanitizer tablets to the condensation pans in the air conditioning units in the attic to prevent the stopping up of lines and leaks. The maintenance supervisor stated they did not document when they completed that. The maintenance supervisor stated they were not aware of a water management plan or legionella prevention plan.