STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375168	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Manor Nursing Center	1340 East 61st Street Tulsa, OK 74136

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41220 Based on record review and interview, the facility failed to prevent abuse for one (#5) of three residents who were sampled for abuse. The administrator identified 125 resident resided in the facility. Findings: A facility policy titled Resident Abuse, Neglect and Misappropriation of Property, read in part . the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion . Resident #5 had diagnoses which included dementia with behaviors and a history of traumatic brain injury. An Incident Report Form, dated 08/10/24, documented Resident #5 had hit RN #1 and RN #1 had then slapped the resident. RN #1 was terminated by the administrator immediately. A police report, an incident report, and a report to the licensure board was made. All staff present were inserviced on the abuse policy. On 08/14/24 at 12:20 p.m., the administrator stated the incident was investigated immediately, RN #1 was fired on the spot and walked them out of the building. The resident was assessed and stated they were not hurt and did not want to go to the hospital. The police and all other agency notifications were made. Our corporate Q.M. and R.M. were notified and came onsite. We began the Q.A. by immediately in-servicing all the staff present. We continued with educating the staff on abuse until all employees were re-educated. The last inservice was held on 08/12/24. A review of the punch detail for the facility from 08/10/24 through 08/13/24 documented a clock out time for RN #1 on 08/10/24 of 10:20 a.m. A current employee list provided by the facility on 08/12/24 did not list RN #1 as an employee.

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